

**Baltimore City Health Department
Ryan White CARE Act, Title I
Quality Improvement Program (QIP)**

Service Category: Primary Care
Final Report
July 2002

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Section 1. Introduction.....	4
Section 2. Methodology	4
table 1. primary care agencies reviewed, dates of review and number of primary care records reviewed	5
table 2. proportion of primary care clients and charts reviewed: qip reviewed charts vs. reported ema title I clients	6
table 3. mean length of primary care service by agency	6
table 4. mean length of client service by race/ethnicity, gender and disease status, primary care clients	7
Section 3. Client Demographics	7
Table 5. Race/ethnicity distribution, primary care clients	8
table 6. race/ethnicity and gender distribution, primary care clients	8
table 7. age range distribution, mean age, primary care clients	8
table 8. age range distribution, by gender, primary care clients	9
table 9. age distribution by hrsa reporting categories	9
table 10. summary of comparison between primary care charts reviewed and bal timore city hiv/aids prevalence	9
table 11. transmission risk distribution by gender, primary care clients	10
table 12. disease status distribution, primary care clients	10
table 13. disease status distribution by race/ethnicity, primary care clients	11
table 14. disease status distribution by gender, primary care clients	11
table 15. summary of comparison between primary care charts reviewed and bal timore city hiv/aids prevalence	11
table 16. cd4 range, last entry, primary care clients	12
table 17. viral load range, last entry, primary care clients	12
table 18. mean cd4 counts of primary care clients for whom there are two cd4 values from cy2001, by treatment status, gender and race/ethnicity	13
table 19. cd4 range distribution of primary care clients for whom there are two cd4 values from cy2001	14
table 20. viral load range distribution of primary care clients for whom there are two viral load values from cy2001 and mean cd4 count	14
table 21. viral load range distribution of primary care clients for whom there are two viral load values from cy2001 and who were on haart during cy2001 and mean cd4 count	15
table 22. viral load range distribution of primary care clients for whom there are two viral load values from cy2001 and who were not on haart during cy2001 and mean cd4 count	15
table 23. insurance coverage distribution, primary care clients	16
table 24. insurance status at second entry of the 159 primary care clients who had no insurance at time of first entry in cy2001	16
table 25. zip code of residence, primary care clients	16

Section 4. Client-level assessment of compliance with EMA primary care standards	17
table 26. baseline medical evaluation: medical and social history	18
table 27. baseline medical evaluation: physical assessment.....	19
table 28. baseline medical evaluation: assessment of vaccination history.....	20
table 29. baseline medical evaluation: provision of vaccinations	21
table 30. number of enrolled primary care clients and proportion receiving and not receiving medical visits, by visit period	22
table 31. provision of antiretroviral treatment which meets the dhhs antiretroviral treatment guidelines	25
table 32. clients for whom haart is clinically indicated	26
table 33. clients for whom haart is not clinically indicated.....	26
table 34. clients for whom haart information is missing/not documented.....	27
table 35. reasons documented for switching haart regimen	28
table 36. prevention of perinatal transmission.....	29
table 37. documentation of provision of annual care	30
Section 5. Agency-Level Compliance with EMA Primary Care Standards.....	31
table 38. services provided directly by primary care agencies or through referral agreements.	32
Section 6. Summary	35
Appendices	39

Section 1. Introduction

The Baltimore City Health Department (BCHD) Title I Quality Improvement Program (QIP) began in FY 2001, the purpose of which is to ensure that people living with HIV/AIDS (PLWH/A) in the EMA have access to quality care and services consistent with the Ryan White CARE Act. Phase I of the QIP initiative focused on adult/adolescent primary care and case management services. To assess the degree to which the Standards of Care were adhered to across the EMA, baseline data was gathered and analyzed from all Title I funded adult/adolescent primary care and case management vendors in the EMA. Information presented in this report focuses exclusively on primary care services.

Section 2. Methodology

The two-day QIP reviews were conducted at 100% of the 13 agencies providing primary care services for adults and adolescents. Data was collected through three avenues: 1) consumer surveys; 2) agency surveys; and 3) client chart abstraction.

Consumer Survey: The Consumer Survey was designed to be completed by the clients. As needed, the Consumer Interviewer completed the tool while posing the questions to the client. The tool focused on three primary areas: a) primary care; b) case management; and c) consumer involvement with the agency. The questions emphasized the type of services provided and client's knowledge about their care rather than on their satisfaction with services. Information related to consumer surveys will be summarized in a separate report.

Agency Survey: Agency surveys were completed by 100% of the primary care vendors. The tool is a self-report of how well the agency complies with the EMA Primary Care Standards of Care for adults and adolescents. No additional verification of information was undertaken. The contact person for the agency was responsible for completing the agency tool. Information related to the agency survey is presented in Section 7.

Client Chart Abstraction: The chart abstraction tool was designed to assess the vendors' adherence to the Standards of Care as established by the Baltimore Title I Planning Council. The review period focused on services provided in CY2001 for Title I funded clients. Vendors were instructed to have charts available for review using the following parameters:

Title I Clients
100% of charts should reflect Title I clients.
CD4 Counts
1/3 of charts should include clients with CD4 counts >500 cells/mm ³ .
1/3 of charts should include clients with CD4 counts 200-500 cells/ mm ³ .
1/3 of charts should include clients with CD4 counts < 200 cells/ mm ³ .
Gender
1/3 of charts should represent women.
Service Initiation
At least 10 charts should represent service initiated in CY2001.

For each chart reviewed one survey instrument was completed. A total of 408 primary care charts were reviewed. The number of records reviewed per site ranged from 16 to 49, with an average of 32 charts reviewed per site [Table 1].

table 1. primary care agencies reviewed, dates of review and number of primary care records reviewed

Agency Name	Dates of review	Number of records reviewed during QIP	% of QIP total
BCHD-STD Clinic	3/4-3/5/2002	30	7%
Bon Secours Hospital	1/24-25/2002	21	5%
Bon Secours Liberty Medical Center	2/14-2/15/2002	24	6%
Chase Brexton Health Services/Cathedral	1/29-30/2002	45	11%
Chase Brexton Health Services/STSC	1/31-2/1/2002	31	8%
JHU/Bayview Medical Center	2/7 & 4/4/2002	36	9%
JHU/County Clinics/STSC	1/23-24/2002	36	9%
JHU/Moore Clinic	3/13-14/2002	49	12%
JHU/OB-GYN Clinic	3/13-14/2002	25	6%
Maryland General Hospital	2/12-2/13/2002	30	7%
People's Community Health Center	2/21-2/22/2002	27	7%
UMD/Adolescent	3/6-7/2002	16	4%
UMD/Evelyn Jordan Center	2/28-3/1/2002	38	9%
TOTAL		408	100%
Average		31.6	8%
Minimum		16	4%
Maximum		49	12%

Based on data reported to BCHD by the Title I funded primary care vendors, a total of 4,791 persons received primary care services during the contract period covering March 1, 2001 to February 28, 2002.¹ While the QIP process reviewed client charts for calendar year 2001 (CY2001), comparisons are made between the reported data and the QIP data presented in Table 2. **Twelve percent (12%) of all Title I primary care charts were reviewed during the QIP process.** The percent of charts reviewed by agency varied based on the size of the program. Programs which report serving larger numbers of primary care clients, such as Chase Brexton Health Services (1,104 clients) and Johns Hopkins Moore Clinic (895), had a lower percentage of charts reviewed, 4% and 5% respectively, compared to smaller programs such as the University of Maryland's Adolescent program (23 clients) which had 70% of its records reviewed. On average, 20% of the Title I primary care charts were reviewed at each site.

¹ The number of Title I primary care clients served by agency is based on reports provided by the vendors to BCHD, and cover the period March 1, 2001 to February 28, 2002. This total is unduplicated at the vendor level, and duplicated then aggregated to give a duplicated EMA-wide client count.

table 2. proportion of primary care clients and charts reviewed: qip reviewed charts vs. reported
ema title I clients

Agency Name	Number of records reviewed during QIP	% of QIP total	Reported # of Title I primary care clients	% of EMA primary care total	% of agency's clients reviewed by QIP
BCHD-STD Clinic	30	7%	515	11%	6%
Bon Secours Hospital	21	5%	151	3%	14%
Bon Secours Liberty Medical Center	24	6%	495	10%	5%
Chase Brexton Health Services/Cathedral	45	11%	1104	23%	4%
Chase Brexton Health Services/STSC	31	8%	186	4%	17%
JHU/Bayview Medical Center	36	9%	299	6%	12%
JHU/County Clinics/STSC	36	9%	400	8%	9%
JHU/Moore Clinic	49	12%	895	19%	5%
JHU/OB-GYN Clinic	25	6%	98	2%	26%
Maryland General Hospital	30	7%	75	2%	40%
People's Community Health Center	27	7%	55	1%	49%
UMD/Adolescent	16	4%	23	<1%	70%
UMD/Evelyn Jordan Center	38	9%	495	10%	8%
TOTAL	408	100%	4,791	12%	
Average	31.6	8%		8%	20%
Minimum	16	4%		<1%	4%
Maximum	49	12%		23%	70%

Data indicate that clients are retained in care over time. Of the charts reviewed, clients had been enrolled in primary care services for an average of 33.7 months [Table 3]. Eight (62%) agencies had clients enrolled in care for longer than eight years. Length of service was determined from the date the chart was opened by the primary care agency to the date of closure in CY2001, or to 12/31/01 for charts that were not closed.

table 3. mean length of primary care service by agency

Agency Name	Mean number of months of service	Min	Max
BCHD-STD Clinic	29.9	3	144
Bon Secours Hospital	40.0	3	82
Bon Secours Liberty Medical Center	34.5	1	92
Chase Brexton Health Services/Cathedral	26.6	2	120
Chase Brexton Health Services/STSC	42.7	2	149
JHU/Bayview Medical Center*	32.0	4	89
JHU/County Clinics	29.7	1	82
JHU/Moore Clinic	41.1	1	133
JHU/OB-GYN Clinic	58.6	8	144
Maryland General Hospital	14.5	2	58
People's Community Health Center	39.6	5	102
UMD/Adolescent	38.3	3	80
UMD/Evelyn Jordan Center	22.4	1	133
TOTAL	33.7	1	149

* Dates of service initiation data was missing/not documented for 2 records and are not included in the analysis in Tables 3 and 4 (n=406 of the 408 records).

In this sample of clients, the average retention in service was almost 3 years, with minimal variations by race/ethnicity and gender [Table 4]. Clients without a CDC-defined AIDS diagnosis had been enrolled in care on average six months longer than those with an AIDS diagnosis.

table 4. mean length of client service by race/ethnicity, gender and disease status, primary care clients

	n	Mean length of service (months)
All clients	406	33.73
Race		
African-American	317	33.64
White	54	36.54
Hispanic	3	48.0
Asian/Pacific-Islander	5	34.6
Native American	1	21.0
Other	4	11.25
Gender		
Male	229	35.03
Female	173	32.12
Transgender	2	36.0
Disease status		
HIV-positive, not AIDS	228	36.56
CDC-defined AIDS	158	29.78
Deceased	6	32.0

Section 3. Client Demographics

Race/Ethnicity, Gender and Age

In the sample of 408 clients, 78% were African-American, 13% were White and 1% Asian/Pacific Islander [Table 5]. Males represented 56% of the sample with females representing 43% [Table 6]. Gender could not be determined or was missing for 2 of the client records. The bulk of clients (75%) were between the ages of 30 and 49 years [Tables 7 and 8]. Additionally, 12% of the clients were between the ages of 50 and 59 years. Table 9 provides a breakdown by HRSA's reporting categories.

The distribution of QIP primary care records by race/ethnicity is similar to the distribution of the HIV/AIDS prevalence within Baltimore City but oversamples women and clients aged 50-59 years [Table 10].

Table 5. Race/ethnicity distribution, primary care clients

Race	Total # (% of column)
African-American	319 (78%)
White	54 (13%)
Hispanic	3 (<1%)
Asian/Pacific-Islander	5 (1%)
Native American	1 (<1%)
Other	4 (1%)
Missing/Not documented ⁱ	22 (5%)
TOTAL	408 (100%)

table 6. race/ethnicity and gender distribution, primary care clients

Race	Male # (% of column)	Female	Trans- gender	Missing/Not documented	Total # (% of column)	Mean age (years)
African-American	173 (75%)	145(83%)	1 (<1%)		319 (78%)	41.2
White	35 (15%)	18 (10%)	1 (1%)		54 (13%)	38.7
Hispanic	3 (1%)				3 (<1%)	41.1
Asian/Pacific-Islander	4 (2%)	1 (<1%)			5 (1%)	34.8
Native American	0 (0%)	1 (<1%)			1 (<1%)	38.2
Other	3 (1%)	1 (<1%)			4 (1%)	28.4
Missing/Not documented	12 (5%)	8 (5%)		2 (100%)	22(5%)	
TOTAL (% of row)	230 (56%)	174 (43%)	2 (<1%)	2 (<1%)	408 (100%)	40.7

table 7. age range distribution, mean age, primary care clients

Age range	Total # (% of column)
13 to 19 years	4 (1%)
20 – 29	39 (10%)
30 – 39	144 (35%)
40 – 49	160 (39%)
50 – 59	47 (12%)
60 – 69	6 (2%)
> 70	2 (1%)
Missing/Not documented	6 (2%)
Total	408 (100%)
Mean age (yrs)	40.7
Min – Max (yrs)	14.5 – 83.0

ⁱ “Missing/Not documented” refers to data either: 1) missing from the chart; or 2) not documented on the Primary Care Instrument. Unless otherwise indicated, these values were included when calculating percentages.

table 8. age range distribution, by gender, primary care clients

Age range	Male # (% of column)	Female	Transgender	Missing/Not documented	Total # (% of column)
13 - 19	1 (<1%)	3 (2%)	—	—	4 (1%)
20 – 29	14 (6%)	23 (13%)	1 (50%)	—	39 (10%)
30 – 39	75 (33%)	69 (40%)	—	—	144 (35%)
40 – 49	102 (45%)	57 (33%)	1 (50%)	—	160 (39%)
50 – 59	28 (12%)	19 (11%)	—	—	47 (12%)
60 – 69	5 (2%)	1 (1%)	—	—	6 (2%)
> 70	1 (<1%)	1 (1%)	—	—	2 (1%)
Missing/Not documented	4 (2%)	1 (1%)	—	1 (100%)	6 (2%)
Total (% of row)	230 (56%)	174 (43%)	2 (<1%)	1 (<1%)	408 (100%)
Mean age (yrs)	41.9	39.2	36.0	22.5	40.7
Min - max (yrs)	19.2-83.0	14.5-82.0	22.1-49.9		14.5 – 83.0

table 9. age distribution by hrsa reporting categories

0 - 12 months	0 (0% of charts reviewed)
1 - 12 years	0 (0% of charts reviewed)
13 - 24 years	20 (5% of charts reviewed)
Women >= 25 years	161 (39% of charts reviewed)
African-American women	145 (36% of charts reviewed)
African-American men	173 (42% of charts reviewed)

table 10. summary of comparison between primary care charts reviewed and baltimore city hiv/aids prevalenceⁱ

	primary care charts reviewed	bal timore city hiv/aids prevalence
% African-American	78%	83%
% White	13%	9%
% Adult Male	56%	63%
% Adult Female	43%	36%
% Ages 30 – 49 years	74%	74%
% Ages 50 – 59 years	12%	6%

Mode of Transmission

Heterosexual contact was noted as the primary mode of transmission in 26% of the charts reviewed [Table 11]. Within this sample, injection drug use (IDU) was noted as the second most frequent mode of transmission (25%). Among men, IDU was the most common risk factor reported (62%), followed by men who have sex with men (27%). Among women, heterosexual contact was the most common risk factor reported (42%) followed by injection drug use (37%). Data related to risk factor was missing or not documented for 75 clients (18%).

ⁱ Baltimore City Health Department, HIV Disease Surveillance Program, “Baltimore City HIV/AIDS Epidemiological Profile”, Third Quarter 2001.

table 11. transmission risk distribution by gender, primary care clients

Transmission risk	Male # (% of column)	Female	Transgender	Missing/Not documented	Total # (% of column)
Injecting drug user (IDU)	63 (62%)	38 (37%)		1 (<1%)	102 (25%)
Heterosexual contact	33 (14%)	73 (42%)		1 (<1%)	107 (26%)
Heterosexual contact and IDU	14 (6%)	21 (12%)			35 (9%)
Men who have sex with men (MSM)	63 (27%)	—	2 (100%)	—	65 (16%)
Hemophilia	2 (<1%)	1 (<1%)	—	—	3 (<1%)
MSM and IDU	—	—	—	—	0 (0%)
Perinatal transmission	—	—	—	—	0 (0%)
Bisexual	4 (2%)	—	—	—	4 (1%)
Missing/Not Documented	44 (19%)	31 (18%)	—	—	75 (18%)
Unknown/Undetermined	7 (3%)	10 (6%)	—	—	17 (4%)
Total (% of row)	230 (56%)	174 (43%)	2 (<1%)	2 (<1%)	408 (100%)

Disease Status

The majority of records reviewed were of clients with an HIV-positive, not AIDS diagnosis (56%) [Table 12]. Of the sample, 158 clients (38%) had a CDC-defined AIDS diagnosis, with an equal proportion represented among African-Americans (39%) and Caucasians (39%). Of the six clients who were deceased, four were African-Americans. The disease status of 4% of African-Americans was either missing or not documented [Table 13].

Among the men, 41% had an AIDS diagnosis, compared to 36% of women. Within the sample, HIV-positive, not AIDS diagnosed accounted for 54% of men and 60% of women. Of the six clients who died, four were men [Table 14].

table 12. disease status distribution, primary care clients

Disease status	Total # (% of column)
HIV-positive, not AIDS	230 (56%)
CDC-defined AIDS	158 (38%)
Deceased	6 (2%)
Missing/Not documented	14 (3%)
Total	408 (100%)

table 13. disease status distribution by race/ethnicity, primary care clients

Disease status	African-American # (% of column)	White	Hispanic	Asian/Pacific Islander	Native American	Other	Missing/Not Documented	Total
HIV-positive, not AIDS	178 (56%)	33 (61%)	1 (33%)	3 (60%)	1 (100%)	2 (50%)	12 (55%)	230 (56%)
CDC-defined AIDS	125 (39%)	21 (39%)	2 (67%)	1 (20%)	—	2 (50%)	7 (39%)	158 (38%)
Deceased	4 (1%)	—	—	1 (20%)	—	—	1 (<1%)	6 (2%)
Missing/Not documented	12 (<14%)	—	—	—	—	—	2 (<1%)	14 (3%)
Total (% of row)	319 (78%)	54 (13%)	3 (<1%)	5 (<1%)	1 (<1%)	4 (<1%)	22 (5%)	408 (100%)

table 14. disease status distribution by gender, primary care clients

Disease status	Male # (% of column)	Female	Transgender	Missing/Not documented	Total # (% of column)
HIV-positive, not AIDS	125 (54%)	104 (60%)	—	1 (50%)	230 (56%)
CDC-defined AIDS	94 (41%)	62 (36%)	1 (50%)	1 (50%)	158 (38%)
Deceased	4 (2%)	1 (<1%)	1 (50%)	—	6 (2%)
Missing/Not documented	7 (3%)	7 (34%)	—	—	14 (3%)
Total (% of row)	230 (56%)	174 (43%)	2 (<1%)	2 (<1%)	408 (100%)

Compared with Baltimore City prevalence data, clients included in this review were less likely to have an AIDS diagnosis noted in the chart [Table 15].

table 15. summary of comparison between primary care charts reviewed and baltimore city hiv/aids prevalenceⁱ

	primary care charts reviewed	baltimore city hiv/aids prevalence
% hiv positive, not aids	56%	55%
% cdc-defined aids diagnosis	38%	45%

Laboratory Values and HAART

Of the sample, 56% had CD4 counts greater than 500 cells/mm³ with 32% having CD4 counts between 250 and 500 cells/mm³ [Table 16]. Nine percent (9%) had a CD4 count of less than 50 cells/mm³, indicating advanced disease progression and the highest risk for opportunistic infections. Viral loads were undetectable for 40% of the sample [Table 17]. Data related to CD4 counts and viral loads was missing or not documented in 6% and 7% of charts reviewed, respectively.

ⁱ “Baltimore City HIV/AIDS Epidemiological Profile”.

table 16. cd4 range, last entry, primary care clients

CD4 range (cells/mm ³)	Total # of clients # (% of column)
<50	36 (9%)
50-100	24 (6%)
101-249	62 (15%)
250-500	132 (32%)
501-1000	114 (28%)
>1,000	114 (28%)
Missing/Not documented	25 (6%)
Total	408 (100%)
Mean CD4	399.27 cells/mm ³

table 17. viral load range, last entry, primary care clients

Viral load range	Total # of clients # (% of column)
Undetectable	162 (40%)
51 - 999	39 (10%)
1,000 – 5,000	39 (10%)
5,001 – 20,000	40 (10%)
20,000 – 100,000	55 (14%)
>100,000	46 (11%)
Missing/Not documented	27 (7%)
Total	408 (100%)

In an effort to examine clinical and treatment indicators, QIP reviewers were asked to abstract documentation of clients' laboratory values (CD4 count and viral load) and treatment with highly active antiretroviral therapy (HAART) at two points during the review period: the first entry in the calendar year and the last entry in the calendar year.

Two CD4 values were recorded from 305 (75%) of the 408 records reviewed [Table 18]. On average, the CD4 count increased by 23.8 cells/mm³ (6.2%) from the first recorded value to the second. **Of the 232 clients on HAART during CY2001, an 11% increase in CD4 count was recorded. Clients not on HAART (n=68) experienced a 5.1% decrease in CD4 count.** Minimal differences were noted between men and women: a 5.9% increase was noted in males and a 7.0% increase was noted in females. Across race/ethnicity, the average CD4 counts were comparable. The average CD4 count for the four Asian/Pacific Islanders was lower than the other groups (228.5 cells/mm³). The smallest increase from the first count to the second was noted among Caucasians.

table 18. mean cd4 counts of primary care clients for whom there are two cd4 values from cy2001, by treatment status, gender and race/ethnicity

	Mean CD4 first value	Mean CD4 second value	Mean change
All clients with two CD4 values (n=305)	380.4	404.2	+23.8 (+6.2%)
Treatment status			
On HAART during CY2001 (n=232)	351.8	390.75	+38.9 (+11%)
Not on HAART during CY2001 (n=68)	465.0	441.03	-23.9 (-5.1%)
Treatment status missing/not documented (n=5)	554.4	530.2	-24.2 (-4.3%)
Gender			
Male (n=167) [73% of all males' charts reviewed]	365.6	387.43	+21.8 (+5.9%)
Female (n=135) [78% of all females' charts reviewed]	400.9	429.2	+28.3 (+7.0%)
Race /Ethnicity			
African-American (n=238) [81% of African-Americans' charts reviewed]	377.4	405.6	+28.2 (+7.4%)
White (n=44) [81% of Whites' charts reviewed]	396.8	400.6	+3.8 (+<1%)
Hispanic (n=2) [66% of Hispanics' charts reviewed]	386.5	522.0	+135.5 (+35%)
Asian/Pacific-Islander (n=4) [80% of Asian/Pacific-Islanders' charts reviewed]	228.5	386.5	+158 (+69.1%)

Table 19 shows the CD4 range distribution for the 305 clients (75%) for whom there are two CD4 values. There are slight shifts in the distribution from the first entry to the second entry. At the first entry, 38% of charts reviewed documented CD4 counts > 250 cells/mm³ and had increased to 40% at the last entry [Table 19].

table 19. cd4 range distribution of primary care clients for whom there are two cd4 values from cy2001

CD4 range (cells/mm ³) (n=305)	First entry Total # of clients # (% of column)	Last entry Total # of clients # (% of column)
<50	33 (11%)	25 (8%)
50-100	55 (18%)	49 (16%)
101-249	102 (33%)	108 (35%)
250-500	22 (7%)	20 (7%)
501-1000	83 (27%)	91 (30%)
>1,000	10 (3%)	12 (4%)
Total	305 (100%)	305 (100%)
Mean CD4	380.4 cells/mm ³	404.2 cells/mm ³

Two viral load measures were documented in 294 (72%) of the records. There are slight shifts in proportion from the first entry to the second entry. The number of **clients with undetectable viral loads increased by 9%** from the first entry (38%) to the second (47%), with a corresponding rise in CD4 count [Table 20].

table 20. viral load range distribution of primary care clients for whom there are two viral load values from cy2001 and mean cd4 count

Viral load range (n=294)	First entry Total # of clients # (% of column)	Last entry Total # of clients # (% of column)
Undetectable	112 (38%)	138 (47%)
50 - 999	26 (9%)	32 (11%)
1,000 – 5,000	27 (9%)	31 (11%)
5,001 – 20,000	23 (8%)	28 (10%)
20,001 – 100,000	56 (19%)	39 (13%)
> 100,000	50 (17%)	26 (9%)
Total	294 (100%)	294 (100%)
Mean CD4	379.4 cells/mm ³	403.3 cells/mm ³

Treatment information and two viral load values were available for 289 of the records. Table 21 shows the viral load distribution for those clients who were on HAART at some point during CY2001 (n=223). Overall, **those who were on HAART had an 11.5% increase in their mean CD4 count**, and a corresponding shift in distribution to lower viral load ranges. At the last entry, **58% of the 223 clients had an undetectable viral load, representing an 11% increase from the first entry.**

Table 22 shows the distribution for those clients who were not on HAART during CY2001 (n=66). For those not on HAART, there is a 5.8% decline in their mean CD4 count and a

corresponding shift in distribution to higher viral load ranges. The percent of clients with an undetectable viral load at the last entry decreased from 12% to 9%.

table 21. viral load range distribution of primary care clients for whom there are two viral load values from cy2001 and who were on haart during cy2001 and mean cd4 count

Viral load range (n=223)	First entry Total # of clients # (% of column)	Last entry Total # of clients # (% of column)
Undetectable	102 (46%)	130 (58%)
50 - 999	18 (8%)	22 (10%)
1,000 – 5,000	16 (7%)	20 (9%)
5,001 – 20,000	13 (6%)	17 (8%)
20,001 – 100,000	35 (16%)	16 (7%)
> 100,000	39 (18%)	18 (8%)
Total	223 (100%)	223 (100%)
Mean CD4	349.5 cells/mm ³	389.7 cells/mm ³

table 22. viral load range distribution of primary care clients for whom there are two viral load values from cy2001 and who were not on haart during cy2001 and mean cd4 count

Viral load range (n=66)	First entry Total # of clients # (% of column)	Last entry Total # of clients # (% of column)
Undetectable	8 (12%)	6 (9%)
50 - 999	7 (11%)	9 (14%)
1,000 – 5,000	10 (15%)	10 (15%)
5,001 – 20,000	10 (15%)	11 (17%)
20,001 – 100,000	20 (30%)	22 (33%)
> 100,000	11 (17%)	8 (12%)
Total	66 (100%)	66 (100%)
Mean CD4	467.1 cells/mm ³	439.7 cells/mm ³

Insurance Status

The client's insurance status was recorded at two points during the calendar year: first entry of the year and last entry of the year. A total of 159 clients were without insurance at the first entry, representing 39% of the records reviewed. At the second entry, 131 clients (32%) lacked insurance. Of the 408 clients, 61 were enrolled in MADAP at the first entry (15%) and 74 (18%) at the second. Medicaid was the most frequent form of insurance, followed by the MADAP program, and private/commercial insurance. A handful of clients had multiple forms of insurance coverage [Table 23].

table 23. insurance coverage distribution, primary care clients

Insurance (n=408)	First entry	Second entry
None	159	131
MADAP	61	74
Medicaid	95	103
Medicare	34	40
Other (mostly other state pharmacy programs or primary care programs)	20	25
Private/Commercial	49	44
Corrections	1	—
Veteran's Administration	0	0

Of the 159 clients who did not have health insurance at the first entry, 80% remained without insurance at the second entry [Table 24]. Eight percent gained access to HIV-related treatment through the MADAP program while 6% obtained Medicaid coverage.

table 24. insurance status at second entry of the 159 primary care clients who had no insurance at time of first entry in cy2001

Insurance n=159	Second entry
None	127
MADAP	13
Medicaid	10
Medicare	2
Other (mostly other state pharmacy or primary care programs)	8
Missing/Not documented	1

Residence

Of the sample, the vast majority of clients resided in Baltimore City (59.6%) Zip codes were documented for 184 of the 408 records [Table 25]. It should be noted that a few clients reside outside of the Baltimore EMA yet were classified by the primary care vendors as being Title I clients

table 25. zip code of residence, primary care clients

ZIP code	# (% of column)				
21217	14 (7.6%)	21215	7 (3.8%)	21230	5 (2.7%)
21218	13 (7.1%)	21216	7 (3.8%)	21001	4 (2.2%)
21206	10 (5.4%)	21224	7 (3.8%)	21133	4 (2.2%)
21229	10 (5.4%)	21244	7 (3.8%)	21208	4 (2.2%)
21202	8 (4.3%)	21201	6 (3.3%)	21239	4 (2.2%)
21207	8 (4.3%)	21221	6 (3.3%)	21205	3 (1.6%)
21213	8 (4.3%)	21223	6 (3.3%)	21211	3 (1.6%)
		21222	5 (2.7%)	21214	3 (1.6%)

21231	3 (1.6%)
21234	3 (1.6%)
21122	2 (1.1%)
21209	2 (1.1%)
20705	1 (0.5%)
20735	1 (0.5%)
20783	1 (0.5%)
20904	1 (0.5%)
20912	1 (0.5%)

21030	1 (0.5%)
21040	1 (0.5%)
21043	1 (0.5%)
21060	1 (0.5%)
21061	1 (0.5%)
21093	1 (0.5%)
21102	1 (0.5%)
21108	1 (0.5%)
21114	1 (0.5%)

21117	1 (0.5%)
21210	1 (0.5%)
21212	1 (0.5%)
21219	1 (0.5%)
21225	1 (0.5%)
21228	1 (0.5%)
21237	1 (0.5%)
21403	1 (0.5%)
Total	184 (100%)

Section 4. Client-level assessment of compliance with EMA primary care standards

Standard 1.1: Initial Baseline Medical Evaluation

Of the 408 records reviewed, 110 clients (27%) entered primary care service during CY 2001 and had an initial baseline medical evaluation completed. Of these clients, 61% were male, 39% female and 76% African-American. Caucasians represented 15% of the sample. Race/ethnicity was missing or not documented for five clients.

Of the 110 clients who had an initial baseline medical evaluation completed, 87% of the records contained a baseline medical evaluation that documented medical history, (Standard 1.1). The subcomponents of the overall Standard are listed in Table 26.

Almost all of the charts (92%) documented the history of HIV-positive status and more than 75% of the charts included information on the client's history of substance use and treatment, psychiatric or mental health disorders, TB testing and current and/or previous medications. For 77% of the women, reproductive history was also documented. Documentation of the client's history of vaccinations was less likely to be noted, with Hepatitis B, Hepatitis A and diphtheria noted in less than 25% of the records.

Physical assessments were routinely documented (93%) as part of the baseline evaluation [Table 27]. Laboratory values were consistently obtained and included CBCs (96%), chemistry panels (98%), LFTs (92%) and CD4 counts (90%). Viral loads were documented in 78% of the records and Hepatitis B and C, 78% and 77%, respectively. Confirmation of HIV by serology, however, was documented only 59% of the time.

Placement of PPD was documented in 47% of the 99 clients for whom the Standard was applicable.

Of the 43 women, PAP smear results were documented in 60% of the records. For all clients, documentation of patient education was noted in 66% of the records.

Clients from this sample appear to be entering these primary care services late in the progression of disease. Of the 110 clients entering primary care services in CY2001, only 17% of the clients had CD4 counts greater than 500 cells/mm³. Twenty eight percent of the clients had CD4 counts less than 100 cells/mm³ and 32% had viral loads greater than 100,000. **Only 7% of the clients had viral loads that were undetectable.**

table 26. baseline medical evaluation: medical and social history

87% of the reviewed charts met the overall standard for documentation of a medical and social history.

% meeting standard (n=110)	source ⁱ	Standard
92%	1.1.a	History of HIV-positive status, Including route of transmission, when and when first diagnosed
59%	1.1.b	Documentation of confirmation of HIV status by serology
76%	1.1.c	History of TB testing, exposure, and/or prophylaxis
47% (n=99)	1.1.d	Documentation of PPD placement Note: 11 charts were excluded because the standard was “not applicable” to the patient, because patient had a prior positive test (n=11) or another reason (n=2).
89%	1.0	Current and previous medications
77% of women (n=43)	1.1.e	Reproductive history: Including history of menses, contraception, pregnancy, childbirth and PAP smear results
60% of women (n=43)	1.1.e	Documentation of most recent PAP smear
88%	1.1.h	History of mental health, substance abuse and appropriate referrals made, If needed

ⁱ Source listed for Standard refers to the “Adult Operational and Performance Standards for Adult HIV Primary Medical Care” ratified by The Greater Baltimore HIV Health Services Planning Council, September 1999 and are indicated by the specific Standard number (e.g., 1.1.a). “DHHS” refers to the “Guidelines for the use of Antiretroviral Agents in HIV Infected Adults and Adolescents and “IDSA” refers to the “2001 USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus”.

table 27: baseline medical evaluation: physical assessment

93% of the reviewed charts met the overall standard for documentation of a physical assessment.

% meeting standard (n=110)	Source	Standard																		
94%	1.0	Review of systems (ROS)																		
96%	1.1.f	Vital signs																		
96%	1.1.f	Weight																		
72%	1.1.f	Height																		
54%	1.0	Nutritional status																		
8%	DHHS	Chest x-ray																		
96%	1.1.g	CBC																		
98%	1.1.g	Chemistry panel																		
92%	1.1.g	LFTs																		
81%	1.1.g	VDRL or RPR																		
63%	1.1.g	Toxoplasmosis IgG ▶ Result: 13% positive of those tested; n=69																		
30%	1.1.g	CMV IgG ▶ Result: 76% positive of those tested; n=33																		
51%	IDSA	Hepatitis A ▶ Result: 16% positive of those tested; n=56																		
78%	1.1.g	Hepatitis B ▶ Result: 40% positive of those tested; n=86																		
77%	1.1.g	Hepatitis C ▶ Result: 45% positive of those tested; n=85																		
28%	1.0	G6-PD																		
90%	1.1.g	CD4 (mean: 294 cells/mm ³) ▶ Result: <table><tr><th>CD4 range (cells/mm³)</th><th>Total # of clients # (% of column)</th></tr><tr><td><50</td><td>24 (22%)</td></tr><tr><td>50-100</td><td>7 (6%)</td></tr><tr><td>101-249</td><td>20 (18%)</td></tr><tr><td>250-500</td><td>28 (26%)</td></tr><tr><td>501-1000</td><td>17 (15%)</td></tr><tr><td>>1,000</td><td>2 (2%)</td></tr><tr><td>Missing/Not documented</td><td>12 (11%)</td></tr><tr><td>Total</td><td>110</td></tr></table>	CD4 range (cells/mm ³)	Total # of clients # (% of column)	<50	24 (22%)	50-100	7 (6%)	101-249	20 (18%)	250-500	28 (26%)	501-1000	17 (15%)	>1,000	2 (2%)	Missing/Not documented	12 (11%)	Total	110
CD4 range (cells/mm ³)	Total # of clients # (% of column)																			
<50	24 (22%)																			
50-100	7 (6%)																			
101-249	20 (18%)																			
250-500	28 (26%)																			
501-1000	17 (15%)																			
>1,000	2 (2%)																			
Missing/Not documented	12 (11%)																			
Total	110																			

78%	1.1.g	Viral Load ► Result:	
		Viral load range	Total # of clients # (% of column)
		Undetectable	8 (7%)
		51 - 999	9 (8%)
		1,000 – 5,000	9 (8%)
		5,001 – 20,000	7 (6%)
		20,000 – 100,000	20 (18%)
		> 100,000	35 (32%)
		Missing/Not documented	22 (20%)
		Total	110
66%	1.1.j	Documentation of discussion of patient education	

table 28: baseline medical evaluation: assessment of vaccination history

% meeting standard (n=110)	Source	Standard
35%	1.1.i	Pneumovax vaccination history
26%	1.1.i	Influenza vaccination history
21%	1.1.i	Hepatitis A vaccination history
25%	1.1.i	Hepatitis B vaccination history
22%	1.1.i	Diphtheria vaccination history
35%	1.1.i	Tetanus vaccination history

table 29: baseline medical evaluation: provision of vaccinations

Of the reviewed charts, 59% met the standard for provision of appropriate vaccinations. Documentation of referrals for vaccination was made for 3% of the clients.

% documenting provision of indicated vaccination (n=110)	Source	Documentation of provision of vaccine
56% (n=30)	IDSA	Pneumovax Clinically indicated if CD4 >200 and not vaccinated during previous 5 years [Of the 54 clients an documented assessment of pneumovax vaccination history during the baseline assessment with a CD4 count of >200, 56% (n=30) received a pneumovax vaccination during the baseline assessment. The number of patients previously vaccinated or not candidates for vaccination was not available; therefore, the level of compliance with this Standard may be higher.]
35% (n=110)	IDSA	Influenza [The number of patients previously vaccinated or not candidates for vaccination was not available; therefore, the level of compliance with this Standard may be higher.]
17% (n=46)	IDSA	Hepatitis A Of the 46 patients documented during the baseline assessment as Hepatitis A negative, 17% were documented as receiving a Hepatitis A vaccination (n=8). Four clients whose Hepatitis A antibody status was not documented were also vaccinated. A total of 12 clients received Hepatitis A vaccination during the baseline assessment.
26% (n=50)	IDSA	Hepatitis B Of the 50 patients documented during the baseline assessment as Hepatitis B negative, 26% were documented as receiving a Hepatitis B vaccination (n=13). Four clients whose Hepatitis B antibody status was not documented were also vaccinated. A total of 17 clients received Hepatitis B vaccination during the baseline assessment.
19% (n=110)	IDSA	Tetanus [The number of patients previously vaccinated or not candidates for vaccination was not available; therefore, the level of compliance with this Standard may be higher.]
16% (n=110)	IDSA	Diphtheria [The number of patients previously vaccinated or not candidates for vaccination was not available; therefore, the level of compliance with this Standard may be higher.]

Ongoing Primary Care

The DHHS guidelines indicate that ongoing medical care for HIV-positive clients should involve medical appointments once every three to four months. For the purposes of the QIP

review, the expectation was that a visit would be provided at least once every four months, and the calendar year was divided into three trimesters to represent three visit periods:

Visit Period 1	January 1 to April 30, 2001
Visit Period 2	May 1 to August 31, 2001
Visit Period 3	September 1 to December 31, 2001

Each active primary care client was expected to receive at least one primary care visit during each trimester [Table 30]. The total number of expected client visits for active primary care clients across the three visit periods is 1099, representing a duplicated count for the 408 clients whose charts were reviewed.

Across each Visit Period, the vast majority of active clients ($\geq 81\%$) were seen by a medical provider according to the DHHS guidelines. On average, less than 13% of the clients did not have a visit during the defined Visit Period and even fewer missed or cancelled their appointment.

If an active primary care client did not have a visit documented during a Visit Period, then the Standards of Care related to ongoing primary medical care were considered not to have been met for that Visit Period. The Standards which require an assessment of current laboratory values (e.g., prophylaxis of opportunistic infection,), and for which there were no laboratory values for that Visit Period, were excluded from analysis during that Visit Period.

table 30. number of enrolled primary care clients and proportion receiving and not receiving medical visits, by visit period

	Visit Period 1 (unduplicated)	Visit Period 2 (unduplicated)	Visit Period 3 (unduplicated)
# patients active during Visit Period	323	368	408
#/% patients who had at least one visit during Visit Period (% of total active patients)	276 (85%)	313 (85%)	331 (81%)
#/% patients who did not have visit during Visit Period	32 (10%)	37 (10%)	52 (13%)
#/% patients who missed their visit during Visit Period	3 (<1%)	10 (3%)	7 (2%)
#/% patients who cancelled their visit during period and did not reschedule visit during Visit Period	2 (<1%)	1 (<1%)	2 (<1%)
#/% patients whose visit status is missing/not documented during Visit Period	10 (3%)	7 (2%)	16 (4%)

Standards 1.2b and 1.3: Documentation of central problem list

Standard 1.3 requires that patient charts contain a central problem list, separate from progress notes, which prioritizes problems for primary care management. Standard 1.2b also requires problem lists and updates. For all Visit Periods, a total of 59% of the charts contained the required information. While many of the charts had captured a history of substance abuse and mental health disorders in the baseline assessment, the information was not consistently documented in a central problem list. Even fewer problem lists identified providers of ancillary

health care, such as specialty services, mental health and substance abuse. It is important to note, however, the total number of clients in need of such services was not known. **Few of the problem lists (11%-14%) identified the need for and provider of case management services.**

Standards 1.2b and 1.3: Central problem list	Visit Period 1 (n=323)	Visit Period 2 (n=368)	Visit Period 3 (n=408)	Total (n=1099)
% of charts reviewed charts meeting standard	61%	60%	56%	59%
% of charts with problem list which identifies history and activity of mental health and substance abuse disorders (Standard 1.3a)	26%	27%	23%	25%
% of charts with problem list which identifies location/provider of ancillary continuing health care (Standard 1.3b)	11%	15%	12%	13%
% of charts with problem list which identifies need for and provider of case management services (Standard 1.3c)	11%	14%	12%	12%

Standards 1.2a and 1.2d: Documentation of physical and laboratory assessments

Standard 1.2d requires CD4 counts and viral loads to be measured every 3-6 months and flexibility may be used depending on the client's health status. Other requirements related to laboratory values and physical assessments, other than temperature, vital signs and weight, are not delineated. The DHHS guidelines recommend conducting a physical assessment and obtaining laboratory values every four months at a minimum.

A total of 81% of the charts reviewed documented a physical assessment and 71% documented assessment of laboratory values. Review of systems (76%), vital signs (80%) and weight (80%) were consistently documented as part of the physical assessment while height (33%) and nutritional status (41%) were less frequently reported.

CD4 counts, viral load testing and CBCs were documented for 72% of the total client visits. Chemistry panels were noted as part of the laboratory assessments in 67% of the records and 63% had liver function tests documented.

Standard 1.2a Physical assessment	Visit Period 1 (n=323)	Visit Period 2 (n=368)	Visit Period 3 (n=408)	Total (n=1099)
% of charts reviewed charts meeting standard	80%	83%	80%	81%
% of charts with physical assessment which documents current and previous medications	76%	77%	74%	76%
% of charts with physical assessment which documents review of systems (ROS)	73%	79%	74%	76%
% of charts with physical assessment which documents vital signs	80%	83%	78%	80%
% of charts with physical assessment which documents weight	80%	83%	77%	80%
% of charts with physical assessment which documents height	32%	33%	33%	33%

% of charts with physical assessment which documents nutritional status	41%	41%	40%	41%
-------------------------------------------------------------------------	-----	-----	-----	-----

Standard 1.2d Laboratory assessment	Visit Period 1 (n=323)	Visit Period 2 (n=368)	Visit Period 3 (n=408)	Total (n=1099)
% of charts reviewed charts meeting standard	71%	70%	70%	71%

% of charts with laboratory assessment which documents complete blood count (CBC)	73%	71%	71%	72%
% of charts with laboratory assessment which documents chemistry panel	69%	67%	66%	67%
% of charts with laboratory assessment which documents liver function tests (LFTs)	66%	63%	61%	63%
% of charts with laboratory assessment which documents CD4 testing	73%	71%	71%	72%
% of charts with laboratory assessment which documents viral load testing	72%	72%	73%	72%

Standards 1.2f and 1.2n: Documentation of patient education

Standards 1.2f and 1.2n require documentation of patient education that focus on the reduction of high-risk behavior for HIV transmission (1.2f) and safer sex practices for both men and women, as appropriate (1.2n). Visit Period 3 reported the highest rate of documentation (50%) while Visit Period 1 reported the lowest rate (45%). Overall, 48% of the records outlined documentation of patient education.

Standards 1.2f and 1.2n Patient education	Visit Period 1 (n=323)	Visit Period 2 (n=368)	Visit Period 3 (n=408)	Total (n=1099)
% of charts reviewed charts meeting standard	45%	49%	50%	48%

Standard 1.2l: Documentation of reporting of illnesses

Standard 1.2l requires that all reportable illnesses be reported to the local health department and that such information be included in the client chart. The table below includes only those charts that documented an occurrence of a reportable illness. On average, **documentation of reporting the illness to the local health department occurred in only 28% of the cases.**

Standard 1.2l Reporting of illnesses	Visit Period 1 (n=50)	Visit Period 2 (n=40)	Visit Period 3 (n=62)	Total (n=152)
% of charts reviewed charts meeting standard	36%	28%	23%	28%

Standard 1.2k: Documentation of addressing advance directives

Standard 1.2k requires that advance directives be “addressed at an appropriate time in the course of the illness”, however, this expectation is not further defined. This led to a more open interpretation by the QIP Reviewers. Some Reviewers felt that advance directives should be addressed only when a patient is experiencing a decline in illness, while others felt that all clients

should have a discussion about advance directives, regardless of their health status.ⁱ Because the Standards allow for a range of interpretation, the analysis of the compliance with this Standard is presented using two methods of calculation: 1) charts which were determined to be “not applicable” are excluded; and 2) all charts are included. When the “not applicable” charts are excluded, documentation of compliance with the Standards is 23%. When all charts are included the rate of compliance drops to 16%.

Standard 1.2k Addressing advance directives	Visit Period 1	Visit Period 2	Visit Period 3	Total
1. Excludes “not applicable” charts % of charts containing documentation of addressing advance directives	22% n=227	23% n=257	23% n=296	23% n=780
2. Includes “not applicable charts % of charts containing documentation of addressing advance directives [Includes “not applicable” charts]	16% n=323	16% n=368	16% n=408	16% n=1099

Antiretroviral therapy

Overall, 81% of charts reviewed have met the DHHS antiretroviral treatment guidelines [Table 31]. Charts did not meet the treatment guidelines if HAART was indicated but not provided [Table 32] or treatment information, or discussion of treatment was not documented or missing [Table 34].

table 31. provision of antiretroviral treatment which meets the dhhs antitretroviral treatment guidelines

	Visit Period 1 (n=323)	Visit Period 2 (n=368)	Visit Period 3 (n=408)	Total of all patient visits (n=1099)
#/% of charts reviewed where DHHS HAART treatment guidelines are met	260 (80% of all clients)	302 (82% of all clients)	330 (81% of all clients)	892 (81% of all clients)

Of the 1099 client visits, HAART was clinically indicated for 71% of the visits [Table 33]. Of those, 64% of clients were continued on a previous HAART regimen and 10% had their regimen changed. Treatment was initiated for an average of 10% of the clients at some point during the calendar year. An additional 10% were offered treatment but declined.

In 4% of client visits, HAART was indicated but a decision was made not to initiate therapy. In these cases, reasons for not initiating therapy were documented in the chart and often related to adherence, substance use, patient education or decision to continue monitoring.

ⁱ A recent article on advance care planning found that only 50% of adults receiving care for HIV had discussed some aspect of end-of-life care with their practitioner and only 38% had completed an advance directive. The study, which uses the HIV Cost and Services Utilization Cohort (HCSUS) found that medical providers discussed care less with blacks and Latinos than with whites. Patients with an IDU risk factor and those with less education communicated least with providers about end-of-life issues. Wenger, N. et. al, “End-of-Life Discussions and Preferences Among Persons With HIV”, JAMA. 2002; 285:2880-2887.

table 32. clients for whom haart is clinically indicated

	Visit Period 1 (n=323)	Visit Period 2 (n=368)	Visit Period 3 (n=408)	Total (n=1099)
#/% of charts reviewed where HAART is clinically indicated	225 (70% of all clients)	264 (72% of all clients)	288 (60% of all clients)	776 (71% of all clients)
#/% (of column) of charts reviewed where previous HAART regimen was continued.	149 (66% of column)	165 (63% of column)	180 (63% of column)	494 (64% of column)
#/% of charts reviewed where previous HAART regimen was switched.	19 (8%)	28 (11%)	31 (11%)	78 (10%)
#/% of charts where HAART is indicated and initiated.	20 (9%)	23 (9%)	34 (12%)	77 (10%)
#/% of charts where HAART is indicated, and not initiated; but charts contain documentation that patient was offered treatment, but declined treatment.	23 (10%)	29 (11%)	25 (9%)	77 (10%)
#/% of charts where HAART is indicated, and not initiated; but charts contain documentation of clinician and patient addressing patient education.	1 (<1%)	1 (<1%)	0 (0%)	2 (<1%)
#/% of charts where HAART is indicated, and not initiated; but charts contain documentation of clinician and patient are in process of addressing substance-abuse related concerns.	0 (0%)	1 (<1%)	0 (0%)	1 (<1%)
#/% of charts where HAART is indicated, and not initiated; but charts contains documentation of continuation of monitoring.	2(1%)	4 (2%)	8 (3%)	13 (2%)
#/% of charts where HAART is indicated, and not initiated; but charts contain documentation of clinician and patient are in process of addressing adherence-related concerns.	4 (2%)	4 (2%)	4 (1%)	12 (2%)
#/% of charts where HAART is indicated, and not initiated; chart does not contain documentation that patient was offered treatment.	7 (3%)	9 (3%)	6 (2%)	22 (3%)
TOTAL #/% of charts reviewed where HAART is clinically indicated	225 (100%)	264 (100%)	287 (100%)	776 (100%)

HAART was determined not to be clinically indicated at 13% of all client visits [Table 33]. Throughout the calendar year, on average 16% of all clients did not have a visit within a defined Visit Period, hence HAART was missing from the medical chart [Table 34]. **When a visit was held, HAART information was documented for 99% of all clients.**

table 33. clients for whom haart is not clinically indicated

	Visit Period 1 (n=323)	Visit Period 2 (n=368)	Visit Period 3 (n=408)	Total (n=1099)
% of charts reviewed where HAART is not clinically indicated	42 (13% of all clients)	47 (13% of all clients)	49 (13% of all clients)	138 (13% of all clients)

table 34. clients for whom haart information is missing/not documented

	Visit Period 1 (n=323)	Visit Period 2 (n=368)	Visit Period 3 (n=408)	Total (n=1099)
% of charts reviewed where HAART information is missing. (Visit not provided during Visit Period.)	51 (16% of all clients)	52 (14% of all clients)	69 (17% of all clients)	172 (16% of all clients)
% of charts reviewed where HAART information is not documented. (Visit provided during Visit Period.)	5 (2% of all clients)	5 (2% of all clients)	3 (1% of all clients)	13 (1% of all clients)
TOTAL #/% of all charts	56 (17% of all clients)	57(15% of all clients)	72 (18% of all clients)	185 (17% of all clients)

Standard 1.2c specifies that clinicians assess and reinforce the treatment plan with clients on HAART. For those clients whose treatment regimen was continued, this patient education was documented at 54% of all client visits.

Standard 1.2c: Documentation of assessment and reinforcement with treatment plan

Standard 1.2c Assessment and reinforcement with treatment plan	Visit Period 1 (n=149)	Visit Period 2 (n=165)	Visit Period 3 (n=180)	Total (n=494)
% of charts reviewed documenting clinician's assessment and reinforcement with the treatment plan (Standard 1.2.c).	52%	53%	57%	54%

Following initiation of treatment, monitoring is indicated at 4 and 8-week intervals. For all visits, 78% had appropriate monitoring at the 4-week interval, but this decreased to 48% of all visits at the 8-week interval.

Standard 1.2d: Documentation of follow-up to initiation of HAART

Standard 1.2d Follow-up to initiation of HAART	Visit Period 1 (n=20)	Visit Period 2 (n=23)	Visit Period 3 (n=34)	Total (n=77)
% of charts reviewed documenting follow-up monitoring visits at 4 weeks of treatment initiation	75%	83%	76%	78%
% of charts reviewed documenting follow-up monitoring visits at 8 weeks of treatment initiation	65%	43%	41%	48%

Following changes in the HAART regimen, monitoring is indicated at 4 and 8-week intervals. For all visits, 53% had appropriate monitoring at the 4-week interval, but this decreased to 31% of all visits at the 8-week interval.

Standard 1.2d: Documentation of follow-up to changes in HAART regimen

Standard 1.2d Follow-up to changes in HAART regimen	Visit Period 1 (n=19)	Visit Period 2 (n=28)	Visit Period 3 (n=31)	Total (n=78)
% of charts reviewed documenting follow-up monitoring visits at 4 weeks of treatment change	74%	50%	42%	53%

% of charts reviewed documenting follow-up monitoring visits at 8 weeks of treatment change	47%	39%	13%	31%
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Standard 1.2e: Documentation of use of resistance testing

For patients who have not achieved optimal viral suppression, resistance testing is recommended prior to changing the treatment regimen. Approximately 29% of patients who had their regimen changed utilized resistance testing prior to the change.

Standard 1.2e Use of resistance testing	Visit Period 1 (n=19)	Visit Period 2 (n=28)	Visit Period 3 (n=31)	Total (n=78)
% of charts reviewed documenting use of resistance testing prior to treatment change	32%	29%	29%	29%

Changes in treatment

Over the course of the calendar year, treatment was changed at 10% of visits (n=78). The most frequently documented reason for changing therapy was due to drug failure (37%), followed closely by toxicity (28%). Issues relating to adherence accounted for 18% of changes.

table 35. reasons documented for switching haart regimen

	#/%
Drug failure	29 (37%)
Toxicity	22 (28%)
Adherence-related issues	14 (18%)
Patient request	5 (6%)
Missing/reason not documented	7 (9%)
Clinical improvement/HAART discontinued	1 (1%)
Total	78

Standard 1.2g: Documentation of preventive therapy

Standard 1.2g requires the documentation of prophylaxis of opportunistic infections according to the *USDHHS/IDSA 2001 Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus*.

[Note: Charts for which there was no current laboratory data available in the chart to assess an indication for prophylaxis therapy or for which therapy was not indicated were excluded from analysis. Only charts for which there was an indication for treatment were included in the analysis. The number of charts included in the analysis is listed in the header row].

Documentation of prophylaxis for *Pneumocystis carinii* pneumonia (91%), *Toxoplasma* Encephalitis (84%) and *Mycobacterium avium* complex (89%) consistently met the treatment guidelines. A limited number of records (12%) documented prophylaxis for cytomegalovirus.

Pneumocystis carinii pneumonia (PCP)

	Visit Period 1 (n=82)	Visit Period 2 (n=102)	Visit Period 3 (n=121)	Total (n=305)
% of charts reviewed charts meeting standard	90%	90%	92%	91%

Toxoplasmic Encephalitis

	Visit Period 1 (n=54)	Visit Period 2 (n=65)	Visit Period 3 (n=82)	Total of all (n=201)
% of charts reviewed charts meeting standard	85%	83%	84%	84%

Mycobacterium avium Complex (MAC)

	Visit Period 1 (n=52)	Visit Period 2 (n=53)	Visit Period 3 (n=68)	Total (n=173)
% of charts reviewed charts meeting standard	88%	86%	91%	89%

Cytomegalovirus Disease (CMV)

	Visit Period 1 (n=54)	Visit Period 2 (n=56)	Visit Period 3 (n=71)	Total (n=181)
% of charts reviewed charts meeting standard	9%	10%	15%	12%

Prevention of perinatal transmission

Federal treatment guidelinesⁱ outline intervention for the prevention of perinatal transmission. From the sample, eight pregnant women were identified. Pregnancy was identified at the sixth week for 3 women, and at the 12th week for 2; time of identification of pregnancy was not documented/missing for the remaining 3 women. Of the 8 pregnant women, 87.5% were receiving antiretroviral therapy according to the treatment guidelines [Table 36]. Treatment was not documented for the remaining woman, however, a referral to a high-risk OB/GYN clinic was noted. Pregnancy outcome was not documented as part of this review effort.

table 36. prevention of perinatal transmission

	#/%
Pregnant women receiving antiretroviral therapy according to treatment guidelines	7 (87.5%)
Treatment not documented	1 (12.5%)
Total	8

ⁱ *Public Health Service Task Force Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States.* Antiretroviral treatment recommendations are also included in the *DHHS Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents.*

Assessment and treatment of pain

Documentation of the patient's level or experience of pain varied by Visit Period from a low of 50% to a high of 64%. A relatively small percentage of the records documented subsequent treatment for pain (8%-15%).

Documentation of assessment of patient's level /experience of pain	Visit Period 1 (n=323)	Visit Period 2 (n=368)	Visit Period 3 (n=408)	Total (n=1099)
% of charts reviewed charts meeting standard	50%	63%	64%	59%
% of patients receiving treatment for pain	8%	11%	15%	12%

Annual care

Annual preventive care includes screening for tuberculosis, serology testing for syphilis, PAP smears for women and immunization against influenza. Among this population surveyed, the Standard for PPD placement was appropriate for 377 clients. Of those clients, 49% had a documented PPD placement during the year and 78% of those were read. Of the clients for whom results were documented (n=147), almost 4% tested PPD positive. For those clients who did not return to the primary care provider to have their PPD read, 0% of the records documented follow-up by the provider agency.

Of the 174 women, PAP smears were documented in 56% of the records. Of those, 23 women were noted to have follow-up to an abnormal PAP smear. The total number of abnormal reports is not known.

Annual serology testing for syphilis was documented in slightly more than half of the clients (58%).

Documentation of immunization against influenza was noted in 56% of the records reviewed.

table 37. documentation of provision of annual care

% meeting standard	Source	Standard
56% of women (n=174)	1.2.h	Documentation of annual PAP smear, and result with appropriate follow-up Of the 97 women who had a documented PAP smear, 23 had documentation of follow-up to an abnormal PAP smear.
49% (n=377)	1.2.i	Documentation of PPD placement Note: 31 charts were excluded from analysis because Standard was "not applicable" to the patient, because patient had a prior positive test (n=30) or another reason (n=1).

78% (n=186)	1.2.i	Documentation of PPD results 78% of the placed PPDs were read (147 of 186), with 4% being a positive result.
0% (n=39)	1.2.i	Documentation of attempts to follow-up with clients who do not return for PPD testing.
58% (n=408)	1.2.j	Syphilis serology: VDRL or RPR
56% (n=372)	IDSA	Immunization: Influenza (Seasonally provided) Note: 36 charts were excluded from analysis because: <ol style="list-style-type: none"> 1) the standard was not applicable because the client did not have a visit during the winter months when the vaccination is provided (n=19); 2) because the patient was offered, but declined (n=12); 3) because the patient's CD4 count was determined to be too low to receive a vaccination (n=4); or 4) was missing/not documented (n=1)

Section 5. Agency-Level Compliance with EMA Primary Care Standards

As part of the QIP process, primary care agencies were asked to complete a 5-page survey (See Appendix 2 for a copy of the instrument). The purpose of this survey was to document the self-reported compliance with the EMA's primary care standards pertaining to agency policies and procedures. All data presented is self-reported by the surveyed agencies and the QIP process did not verify the agencies' responses.

Table 38 lists the services directly provided by the primary care agencies and those provided through referral agreements. The 13 primary care agencies provide a large number of other services to clients, such as case management, client advocacy and transportation services. Vendors also indicate having access to a wide array of services through referral agreements. Services that are more likely to be provided through referral than directly include housing assistance, food/nutrition, dental care, legal services, buddy/companion services and enriched life skills.

table 38. services provided directly by primary care agencies or through referral agreements.

Service (n=13)	% which provide service directly	% with referral agreements for service
Ambulatory Health Care	85%	15%
Client Advocacy	85%	31%
Transportation	85%	46%
Case Management	77%	31%
Viral Load Testing	77%	64%
Direct Emergency Assistance	69%	38%
Mental Health Services	69%	31%
Outreach	62%	38%
Substance Abuse Treatment	62%	62%
Counseling	62%	31%
Co-morbidity Services	54%	23%
Housing Assistance	46%	69%
Food/Nutrition	31%	77%
Dental Care	31%	69%
Legal Services	15%	62%
Other: Adherence	15%	15%
Other: Pharmacy	15%	8%
Enriched Life Skills	8%	23%
Other: OB/GYN	8%	8%
Other: HIV/CTS	8%	8%
Buddy/Companion	0%	46%

Licensing, Knowledge, Skills and Experience

All 13 vendors indicate 100% compliance with professional licensure and professional supervision and/or consultation provided by HIV experts. Clinical staff provide direct HIV services to more than 20 clients. More than 90% report staff having a minimum of 20 CME hours per year in HIV/AIDS course work.

EMA Primary Care Standard	Percent of agencies reporting that they are in compliance with standard
Do all staff involved in the delivery of health care have the appropriate and current professional licensure from the state of Maryland? (Standard 2.1.a)	100%
Is professional supervision and/or consultation of clinical staff provided by practitioners who have extensive HIV expertise and active HIV practices themselves? (Standard 2.1.b)	100%
Do clinical staff who provide direct HIV clinic services have an active practice of greater than twenty HIV-infected patients? (Standard 2.1.c)	100%

Are medical practitioners encouraged to develop the expertise needed to provide the specialized care that HIV-infected patients need? (Standard 2.1.c)	100%
Do clinical staff have a minimum of 20 CME hours per year In HIV/AIDS-specialty course work? (Standard 2.1.d. Note The 2001-ratified standards require 30 CME hours annually. The prior standard was used for this agency survey.)	92%

Patient Rights and Confidentiality

Agencies indicate complete compliance with policies and procedures related to security of medical information, patient grievance, confidentiality, eligibility for service, client rights and responsibilities, and termination of care.

EMA Primary Care Standard	Percent of agencies reporting that they are in compliance with standard
Does the agency have written policies and procedures that assure patient confidentiality with regard to transmission, maintenance and security of medical information? (Standard 2.2.b)	100%
Does the agency have written policies and procedures regarding: Patient grievance? (Standard 2.2.c)	100%
Does the agency have written policies and procedures regarding: Confidentiality? (Standard 2.2.c)	100%
Does the agency have written policies and procedures regarding: Eligibility for service? (Standard 2.2.c)	100%
Does the agency have written policies and procedures regarding: Patient rights and provider expectations of patients and termination of care by either the patient or the provider? (Standard 2.2.c)	100%

Access, Care and Provider Continuity

Twenty-four hour coverage was established at all of the primary care agencies and mechanisms were reported to be in place for urgent care evaluation and triage. Many respondents cited using triage nurses to address urgent care needs with same day appointments scheduled as indicated. Referral procedures were also reported to be in place for 100% of the primary care agencies. Referrals for inpatient care existed for 92% of the vendors.

Seventy percent reported having a no-show rate of less than 50% while 15% reported having a no-show rate exceeding 50%. Fifteen percent (15%) of the respondents indicated that their the no-show rate has not been calculated. Many of the respondents outlined procedures that have been implemented to facilitate patients' adherence with medical appointments. The most frequently noted interventions included: assisting with transportation, pre-appointment phone calls, pre-appointment letter, and post-appointment letter. Several indicated utilizing a home visit and contacting the patient's case manager.

A quality assurance program is reported to be in place at 92% of the vendors.

EMA Primary Care Standard	Percent of agencies reporting that they are in compliance with standard
Does the agency have a procedure in place for 24-hour call coverage? (Standard 2.3.a)	100%
Does the agency have mechanisms in place for urgent care evaluation and/or triage? (Standard 2.3.b)	100%
Does the agency have mechanisms in place for referral to inpatient care and return to ambulatory care? (Standard 2.3.c)	92%
Does the agency's no-show rate for ambulatory care exceed 50%? (Standard 2.3.d. Note: The previous Standards specifically required agencies with a no-show rate of greater than 50% to implement procedures to reduce the rate. The current Standards require agencies to show follow-up attempts to reduce the no show rate. The prior Standard was used for this agency survey.)	15% - Yes 70% - No 15% - Not calculated
Are there procedures in place to assure continuity with referring providers? (Standard 2.3.g)	100%
Does the agency have an on-going quality improvement/quality assurance program that identifies areas for improvement and subsequent actions taken? (Standard 2.4)	92%

As part of continuity of care standards, agencies were asked to document which medical subspecialties and ancillary health and social services they provide directly, through referral, or do not have access to the service. These specific services are listed in Standard 2.3.e.

Subspecialty service	Provide service directly	Provide service through referral	Service not available
Social work and case management services	85%	15%	0%
Obstetrics & Gynecology	62%	62%	0%
Substance Abuse treatment	62%	64%	0%
Psychiatry	46%	54%	0%
Nutritional counseling from a Registered Dietician	46%	46%	0%
Social work and case management services	46%	69%	0%
ART counseling/therapy for pregnant women	38%	54%	8%
Palliative care	31%	69%	0%
Neurology	23%	92%	0%
Dermatology	23%	92%	0%
Dentistry	23%	85%	8%
Gastroenterology	15%	92%	0%
Endocrinology	15%	92%	0%
Pulmonary	15%	92%	0%
Information with inherited coagulopathies and referral to the local federally funded hemophilia treatment center	15%	77%	8%
Ophthalmology	8%	92%	0%
Cardiology	8%	92%	0%
Oncology	8%	92%	0%
Access to clinical investigations	0%	85%	0%

Complementary therapies	0%	77%	15%
Chiropractic	0%	85%	15%
Massage Therapy	0%	8%	0%

Section 6. Summary

The QIP process provided a systematic review of compliance to the EMA's Standards of Care for all primary care vendors supported by Title I. On average, 20% of the Title I primary care charts were reviewed at each site. As expected, the percent of charts reviewed by agency varied based on the size of the program.

The charts reviewed were similar to the distribution of the HIV/AIDS prevalence within Baltimore City but over-sampled women, clients aged 50-59 years and heterosexual mode of transmission. Of the sample, 56% had CD4 counts greater than 500 cells/mm³ with 32% having CD4 counts between 250 and 500 cells/mm³. Nine percent (9%) had a CD4 count of less than 50 cells/mm³, indicating advanced disease progression and the highest risk for opportunistic infections. Viral loads were undetectable for 40% of the sample.

With a few exceptions, many of the standards were consistently met and data clearly show that clients are being retained in care, with the average retention in service of almost three years for this sample of clients. Minimal variations were noted by race/ethnicity gender.

In respect to the specific standards of care, several key points should be highlighted:

- On average, the CD4 count increased by 23.8 cells/mm³ (6.2%) from the first recorded value to the second. Two CD4 values were documented in 305 (75%) of the records. At the first entry, 38% of charts reviewed documented CD4 counts > 250 cells/mm³ and had increased to 40% at the last entry. Two viral load measures were documented in 294 (72%) of the records. The number of **clients with undetectable viral loads increased by 9%** from the first entry (38%) to the second (47%), with a corresponding rise in CD4 count.
- Treatment information and two viral load values were available for 289 (71%) of the records. Overall, those who were **on HAART had an 11.5% increase in their mean CD4 count**, and a corresponding shift in distribution to lower viral load ranges. At the last entry, 58% of the 223 clients had an **undetectable viral load, representing an 11% increase** from the first entry. Minimal differences in changes in CD4 counts were noted between men and women: a 5.9% increase was noted in males and a 7.0% increase was noted in females. Across race/ethnicity, the average CD4 counts were comparable.
- A total of 159 clients were without insurance at the first data collection point, representing 39% of the records reviewed. At the second entry, 131 clients (32%) lacked insurance. A significant number were enrolled in MADAP (8%), Medicaid (6%) and a handful had multiple forms of insurance coverage. Of the 159 clients who did not have health insurance at the first entry, 80% remained without insurance at the second entry.

- Almost all of the charts (92%) documented the history of HIV-positive status and more than 75% of the charts included information on the client's history of substance use and treatment, psychiatric or mental health disorders, TB testing and current and/or previous medications. For 77% of the women, reproductive history was also documented.
- Of the charts reviewed, 87% met the overall standard for documentation of a medical and social history and 93% met the overall standards for documentation of a physical assessment. Of the 110 clients who had an initial baseline medical evaluation completed, 87% of the records contained a baseline medical evaluation that documented medical history.
- Across each Visit Period, the vast majority of active clients ($\geq 81\%$) were seen by a medical provider according to the DHHS guidelines. On average, less than 13% of the clients did not have a visit during the defined Visit Period and even fewer missed or cancelled their appointment.
- A total of 81% of the charts reviewed documented a physical assessment and 71% documented assessment of laboratory values. CD4 counts, viral load testing and CBCs were documented for 72% of the total client visits.
- Overall, **81% of charts reviewed met the DHHS antiretroviral treatment guidelines.** Of the 1099 client visits, HAART was clinically indicated for 71% of the visits. Of those, 64% of clients were continued on a previous HAART regimen and 10% had their regimen changed. Treatment was initiated for an average of 10% of the clients at some point during the calendar year. An additional 10% were offered treatment but declined.
- When placed on HAART, documentation of the treatment regimen was consistently noted in the charts. In 4% of client visits, HAART was indicated but a decision was made not to initiate therapy. In these cases, reasons for not initiating therapy were documented in the chart and often related to adherence, substance use, patient education or decision to continue monitoring.
- For all visits, 78% had appropriate monitoring at the 4-week interval following initiation of HAART.
- Over the course of the calendar year, treatment was changed at 10% of visits (n=78). The most frequently documented reason for changing therapy was due to drug failure (37%), followed closely by toxicity (28%). Issues relating to adherence accounted for 18% of changes.
- Documentation of prophylaxis for *Pneumocystis carinii* pneumonia (91%), Toxoplasmic Encephalitis (84%) and *Mycobacterium avium* complex (89%) consistently met the treatment guidelines.

- Of the eight (8) pregnant women included in the sample, 87.5% were receiving antiretroviral therapy according to the treatment guidelines.
- All 13 vendors report 100% compliance with professional licensure, professional supervision and/or consultation provided by HIV experts, and policies and procedures related to security of medical information, patient grievance, confidentiality, eligibility for service, client rights and responsibilities, and termination of care.
- Twenty-four hour coverage was established at all of the primary care agencies and mechanisms were reported to be in place for urgent care evaluation, triage and referrals.

Several key findings were identified and include the following:

- Clients from this sample appear to be initiating primary care services at these Title I agencies at a more advanced stage of the disease. Of the 110 clients receiving a baseline evaluation in CY2001, only 17% of the clients had CD4 counts greater than 500 cells/mm³. Twenty eight percent of the clients had CD4 counts less than 100 cells/mm³ and 32% had viral loads greater than 100,000. Only 7% of the clients had viral loads that were undetectable. It is important to note that this baseline evaluation may not represent the initial entry into the health care system for treatment of HIV for many of the clients in this sample. Some of the clients may have previously received care at other primary care agencies, in the corrections system, or from outside the EMA. It is also possible that clients are receiving primary care at multiple sites. Further investigation is needed to determine if clients are newly entering the care system or changing their primary care provider, and for what reason these changes are being made.
- As part of the baseline medical evaluation, placement of PPD was documented in 47% of the 99 clients for whom the standard was applicable. Annual PPD placement was appropriate for 377 clients. Of those clients, 49% had a documented PPD placement during the year and 78% of those were read. Of the clients for whom results were documented (n=147), almost 4% tested PPD positive. For those clients who did not return to the primary care provider to have their PPD read, 0% of the records documented follow-up by the provider agency.
- Of the reviewed charts, 59% met the standard for provision of appropriate vaccinations. The number of patients previously vaccinated or not candidates for vaccination was not available; therefore, the level of compliance with this standard may be higher. It should be noted, however, that documentation of client's history of vaccinations was not consistently reported, with Hepatitis B, Hepatitis A and diphtheria noted in less than 25% of the records.
- A limited number of records (12%) documented prophylaxis for cytomegalovirus. It should be noted that local practice relies more heavily on ophthalmic examinations when compared to the IDSA guidelines. The review did not capture documentation of ophthalmic exams.

- Of the 174 women included in the sample, PAP smears were documented in 56% of the records. Of those, 23 women were noted to have follow-up to an abnormal PAP smear. The total number of abnormal reports was not known.
- Annual syphilis testing was documented in only 58% of the reviewed charts.
- Resistance testing prior to regimen change was not consistently used. Approximately 29% of patients who had their regimen changed utilized resistance testing prior the regimen change. After a change was been made, monitoring was conducted at the 4-week interval for 53% of all visits but decreased to 31% at the 8-week interval.
- Documentation of patient education was not consistently reported. For those clients whose HAART regimen was continued during the calendar year, patient education was documented at 54% of all client visits. When the education focused on the reduction of high-risk behavior for HIV transmission and safer sex practices, 48% of the records included appropriate documentation.
- While many of the charts had captured a history of substance abuse and mental health disorders in the baseline assessment, the information was not consistently documented in a central problem list. Even fewer problem lists identified providers of ancillary health care, such as specialty services, mental health and substance abuse. It is important to note, however, the total number of clients in need of such services was not known. Few of the problem lists (11%-14%) identified the need for and provider of case management services.
- On average, documentation of reporting a reportable illness to the local health department occurred in only 28% of the cases. It is important to note that the data do not include charts for patient who were not seen during a Visit Period. If those were included, the average compliance rate would decrease to 15%.
- Documentation of advance directives is limited and ranges from 16% to 23%.
- Client eligibility continues to be an issue that vendors struggle with. Several clients are noted to have multiple forms of insurance or reside in areas outside of the EMA. Confirmation of HIV by serology was documented only 59% of the time.
- Fifteen percent of the primary care vendors indicated that their the no-show rate has not been calculated or tracked.

Overall, the Title I primary care vendors have successfully implemented HAART therapy and was reflected in increases in CD4 counts and decreases in viral loads. Clients were seen by the primary care provider according to the DHHS guidelines and have been maintained in care over time.

Appendices

1. Primary Care Medical Services Client Chart Abstraction Instrument, January 2002
2. Primary Care Medical Services Agency Survey, January 2002

**BCHD Quality Improvement Project
Primary Care Medical Services
Client Chart Abstraction Instrument**

Section 1. Reviewer Information

Instructions: Complete the requested information.

1.1	Date of review	
1.2	Name of reviewer	
1.3	Client chart ID#	
1.4	Time start chart review	
1.5	Time end chart review	
1.6	Total time for chart review (hrs:min)	
1.7	Chart start date (Date of first entry)	
1.8	Chart end date (Date of last entry)	
1.9	Dates of services reviewed in chart	<input type="checkbox"/> 1/ 1/ 01 to 12/ 31/ 01 (Default) ___ / ___ / ____ to ___ / ___ / ____
1.10	Was chart opened/ primary care services initiated during CY2001?	<input type="checkbox"/> Yes <input type="checkbox"/> No; chart opened prior to 2001 <input type="checkbox"/> Not documented
1.10	Was chart closed/ client terminated from primary care services during CY2001?	<input type="checkbox"/> Yes <input type="checkbox"/> No; client continued to receive services <input type="checkbox"/> Not documented
1.11	Agency code	
1.12	Verification of Title I eligibility [Check if documented in chart]	<input type="checkbox"/> Meets income eligibility criteria <input type="checkbox"/> Meets HIV-infection status criteria <input type="checkbox"/> Meets Baltimore EMA residency requirement criteria

Section 2. Client Demographics

Instructions: Provide the requested information based on information contained in the client's primary care chart.

2.1 Client date of birth	____ / ____ / ____ <input type="checkbox"/> Age on 12/ 31/ 01 if no dob in chart ____ <input type="checkbox"/> Not documented in chart
2.2 Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Not documented in chart
2.3 Race/ Ethnicity	<input type="checkbox"/> White <input type="checkbox"/> Black/ African-American <input type="checkbox"/> Hispanic/ Latino/ a <input type="checkbox"/> Asian/ Pacific Islander <input type="checkbox"/> American Indian/ Alaska Native <input type="checkbox"/> Other: Specify: <input type="checkbox"/> Not documented in chart

2.4 HIV risk factor	<input type="checkbox"/> Men who have sex with men (MSM) <input type="checkbox"/> Injecting drug user (IDU) <input type="checkbox"/> MSM and IDU <input type="checkbox"/> Heterosexual contact <input type="checkbox"/> Heterosexual contact and IDU <input type="checkbox"/> Hemophilia/ coagulation disease or receipt of blood products <input type="checkbox"/> Undetermined/ unknown, risk not reported <input type="checkbox"/> Perinatal transmission <input type="checkbox"/> Other: Specify: <input type="checkbox"/> Not documented in chart
2.5 City client residing in on 1/ 1/ 01 (or first entry In 2001)	_____ <input type="checkbox"/> Unknown <input type="checkbox"/> Not documented In chart
2.6 Chart contains signed consent for release of information.	<input type="checkbox"/> Yes <input type="checkbox"/> No

2.7a Client health Insurance on 1/ 1/ 01 (or first entry In 2001) [Check all that apply]	<input type="checkbox"/> None <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIPS <input type="checkbox"/> Maryland AIDS Drug Assistance Program <input type="checkbox"/> Medicare <input type="checkbox"/> Private/ Commercial <input type="checkbox"/> Veteran's Administration <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown [client reports not knowing] <input type="checkbox"/> Other: Specify: <input type="checkbox"/> Not documented in chart
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2.7b Client health Insurance on 12/ 31/ 01 (or last entry In 2001) [Check all that apply]	<input type="checkbox"/> None <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIPS <input type="checkbox"/> Maryland AIDS Drug Assistance Program <input type="checkbox"/> Medicare <input type="checkbox"/> Private/ Commercial <input type="checkbox"/> Veteran's Administration <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown [client reports not knowing] <input type="checkbox"/> Other: Specify: <input type="checkbox"/> Not documented In chart
---------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

2.8a HIV-disease status on 1/ 1/ 01 (or first entry In 2001)	<input type="checkbox"/> HIV-positive, not AIDS Date of dx: __/ __/ __ <input type="checkbox"/> Date not documented In chart <input type="checkbox"/> CDC defined AIDS Date of dx: __/ __/ __ <input type="checkbox"/> Date not documented In chart <input type="checkbox"/> Unknown; client states he/ she does not know HIV status <input type="checkbox"/> HIV-negative Date of dx: __/ __/ __ <input type="checkbox"/> Date not documented In chart <input type="checkbox"/> Not documented in chart
--------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

2.8b HIV-disease status on 12/ 31/ 01 (or last entry In 2001)	<input type="checkbox"/> Dead Date of death: __/ __/ __ <input type="checkbox"/> Date not documented In chart <input type="checkbox"/> HIV-positive, not AIDS Date of dx: __/ __/ __ <input type="checkbox"/> Date not documented In chart <input type="checkbox"/> CDC defined AIDS Date of dx: __/ __/ __ <input type="checkbox"/> Date not documented In chart <input type="checkbox"/> Unknown; client states he/ she does not know HIV status <input type="checkbox"/> HIV-negative Date of dx: __/ __/ __ <input type="checkbox"/> Date not documented In chart <input type="checkbox"/> Not documented in chart
---------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

2.9a CD4/Viral Load on 1/ 1/ 01 (or first entry In 2001)	CD4 ____ cells/uL Date of test: __/ __/ __ <input type="checkbox"/> Date not documented In chart Viral load: _____ Date of test: __/ __/ __ <input type="checkbox"/> Date not documented In chart <input type="checkbox"/> Unknown [not tested; client reports not knowing] <input type="checkbox"/> Not documented in chart
----------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

2.9b CD4/Viral Load on 12/ 31/ 01 (or last entry In 2001)	CD4 ____ cells/uL Date of test: __/ __/ __ <input type="checkbox"/> Date not documented In chart Viral load: _____ Date of test: __/ __/ __ <input type="checkbox"/> Date not documented In chart <input type="checkbox"/> Unknown [not tested; client reports not knowing] <input type="checkbox"/> Not documented in chart
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2.10a Client on HAART on 1/ 1/ 01 (or first entry In 2001)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown [client reports not knowing] <input type="checkbox"/> Other: Specify: <input type="checkbox"/> Not documented in chart
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2.10b Client on HAART on 12/ 31/ 01 (or last entry In 2001)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown [client reports not knowing] <input type="checkbox"/> Other: Specify: <input type="checkbox"/> Not documented in chart
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Section 3. Initial/Baseline Medical Evaluation

Instructions:

The client record should be reviewed only for the period of calendar year 2001 (CY2001). Only those services which were provided during CY2001 should be reviewed by the reviewer.

3.0 Initial/ Baseline Medical Evaluation	<input type="checkbox"/> Initial/ baseline medical evaluation provided after 1/ 1/ 01 ▶ GO TO 3.1, below <input type="checkbox"/> Initial/ baseline medical evaluation provided before 1/ 1/ 01 ▶ GO TO 4.0, p 7 <input type="checkbox"/> Record does not adequately document date of Initial/ baseline medical evaluation ▶ GO TO 4.0, p 7
-------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Standard/ Guideline	Standard/ Guideline Met	Notes
3.1 Initial/ baseline medical evaluation documents medical history	<input type="checkbox"/> Yes , chart contains evidence that standard was met. <input type="checkbox"/> No , chart does not contain evidence that standard was met. ▶ Check areas documented in medical history <input type="checkbox"/> History of HIV-positive status, Including route of transmission, when and when first diagnosed <input type="checkbox"/> History of TB testing, exposure, and/ or prophylaxis <input type="checkbox"/> Current and previous medications <input type="checkbox"/> Psychiatric/ mental health history <input type="checkbox"/> Substance abuse history and treatment <input type="checkbox"/> Reproductive history: Including history of menses, contraception, pregnancy, childbirth and PAP smear results <input type="checkbox"/> Past vaccinations (check all that are documented): <div style="margin-left: 20px;"> <input type="checkbox"/> Pneumovax <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Tetanus <input type="checkbox"/> Diphtheria </div>	
3.2 Initial/ baseline medical evaluation documents physical assessment	<input type="checkbox"/> Yes , chart contains evidence that standard was met. <input type="checkbox"/> No , chart does not contain evidence that standard was met. ▶ Check areas documented in physical assessment <input type="checkbox"/> Review of systems (ROS) <input type="checkbox"/> Vital signs <input type="checkbox"/> Weight <input type="checkbox"/> Height	

	<input type="checkbox"/> Nutritional status <input type="checkbox"/> Chest x-ray <input type="checkbox"/> Laboratory data <input type="checkbox"/> CBC <input type="checkbox"/> Chemistry panel <input type="checkbox"/> LFTs <input type="checkbox"/> VDRL or RPR <input type="checkbox"/> Toxoplasmosis IgG ▶ Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> CMV IgG ▶ Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Hepatitis A ▶ Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Hepatitis B ▶ Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Hepatitis C ▶ Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> G6-PD <input type="checkbox"/> CD4 ▶ Result: _____ cells/uL <input type="checkbox"/> Viral Load ▶ Result: _____
3.3 Documentation of confirmation of HIV status by serology	<input type="checkbox"/> Yes , chart contains evidence that standard was met. <input type="checkbox"/> No , chart does not contain evidence that standard was met.
3.4 Documentation of PPD placement <i>[Note: Results and follow-up should be documented in Section 5.0, Annual Clinical Care, question 5.1, p 15.]</i>	<input type="checkbox"/> Yes , chart contains evidence that PPD skin test was placed. <input type="checkbox"/> No , chart does not contain evidence that standard was met. <input type="checkbox"/> This standard not applicable to this client's situation; specify: <input type="checkbox"/> Patient has prior positive test; PPD testing not indicated <input type="checkbox"/> Other/ Specify:

3.5	Documentation of assessment of provisions of vaccinations, if indicated	<input type="checkbox"/> Yes , chart contain evidence that standard was met. ▶ Check vaccinations given during visit : <input type="checkbox"/> Pneumovax [Clinically indicated if CD4 >200 and not vaccinated during previous 5 years) <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Tetanus <input type="checkbox"/> Diphtheria ▶ <input type="checkbox"/> Referrals given to patient for vaccinations ▶ <input type="checkbox"/> Patient was offered, but declined vaccinations <input type="checkbox"/> No , chart does not contain evidence that standard was met.
3.6	Documentation of most recent PAP smear Gynecologic evaluation with pelvic exam and PAP smear at baseline, repeated at 6 months and annually thereafter. <i>[Note: Results and follow-up should be documented in Section 5.0, Annual Clinical Care , question 5.4, p 15.]</i>	<input type="checkbox"/> Yes , chart contains evidence that standard was met. <input type="checkbox"/> No , chart does not contain evidence that standard was met. <input type="checkbox"/> This standard not applicable : Client is male.
3.7	Documentation of discussion of patient education	<input type="checkbox"/> Yes , chart contains evidence that standard was met. <input type="checkbox"/> No , chart does not contain evidence that standard was met.
3.8	Documentation of assessment of history of mental health, substance abuse and appropriate referrals made, If needed	<input type="checkbox"/> Yes , chart contains evidence that standard was met. <input type="checkbox"/> No , chart does not contain evidence that standard was met.

Section 4. Ongoing primary medical care

Instructions:

This section should be completed for all clients to assess the on-going medical care provide to patients. The instrument assumes that clients provided with appointments for monitoring and care at least every four months. Please review the patient record and complete the instrument for each of these trimesters: **Visit period 1** (January 1 - April 30, 2001); **Visit period 2** (May 1 -August 31, 2001); and **Visit period 3** (September 1 - December 31, 2001). .

Note: If there are multiple visits during the period and results data is to be abstracted, then record data from the **last** visit for that period (e.g., record the most **last** lab value if there are multiple lab values during that visit period.)

Visit period 1 January 1 - April 30, 2001.	Visit period 2 May 1 - August 31, 2001	Visit period 3 September 1 - December 31, 2001
<input type="checkbox"/> Patient was an active client during the period Jan 1 - April 30, 2001 ► Complete this column <input type="checkbox"/> Patient was an enrolled client after April 30, 2001 <input type="checkbox"/> ► GO TO Visit Period 2 Column ◀	<input type="checkbox"/> Patient was an active client during the period May 1 - August 31, 2001 ► Complete this column <input type="checkbox"/> Patient was an enrolled client after Aug 31, 2001 <input type="checkbox"/> ► GO TO Visit Period 3 Column ◀	<input type="checkbox"/> Patient was an active client during the period Sept 1 - Dec 31, 2001 ► Complete this column

4.1. Frequency of patient visits during this period.

a. Check only if documented In the patient chart	a. Check only if documented In the patient chart	a. Check only if documented In the patient chart
<input type="checkbox"/> Scheduled clinic visit provided during this period <input type="checkbox"/> Scheduled clinic visit not provided during this period <input type="checkbox"/> Appointment scheduled, but cancelled by patient <input type="checkbox"/> Appointment scheduled, but patient missed appointment (no show)	<input type="checkbox"/> Scheduled clinic visit provided during this period <input type="checkbox"/> Scheduled clinic visit not provided during this period <input type="checkbox"/> Appointment scheduled, but cancelled by patient <input type="checkbox"/> Appointment scheduled, but patient missed appointment (no show)	<input type="checkbox"/> Scheduled clinic visit provided during this period <input type="checkbox"/> Scheduled clinic visit not provided during this period <input type="checkbox"/> Appointment scheduled, but cancelled by patient <input type="checkbox"/> Appointment scheduled, but patient missed appointment (no show)
b. In addition to scheduled visit(s), check if client had additional appointments for: (check all that apply) <input type="checkbox"/> Follow-up to treatment initiation/ treatment changes <input type="checkbox"/> Toxicity/ side-effects/ adverse drug reactions <input type="checkbox"/> New HIV-related symptoms <input type="checkbox"/> Other/ Specify:	b. In addition to scheduled visit(s), check if client had additional appointments for: (check all that apply) <input type="checkbox"/> Follow-up to treatment initiation/ treatment changes <input type="checkbox"/> Toxicity/ side-effects/ adverse drug reactions <input type="checkbox"/> New HIV-related symptoms <input type="checkbox"/> Other/ Specify:	b. In addition to scheduled visit(s), check if client had additional appointments for: (check all that apply) <input type="checkbox"/> Follow-up to treatment initiation/ treatment changes <input type="checkbox"/> Toxicity/ side-effects/ adverse drug reactions <input type="checkbox"/> New HIV-related symptoms <input type="checkbox"/> Other/ Specify:

4.2 Patient chart contains central problem list, separate from progress notes, which prioritizes problems for primary care management		
Visit period 1 January 1 - April 30, 2001.	Visit period 2 May 1 - August 31, 2001	Visit period 3 September 1 - December 31, 2001
<input type="checkbox"/> Yes , chart contains evidence that standard was met. ▶ Check areas contained In the central problem list : <input type="checkbox"/> Includes history and activity of mental health and substance abuse disorders <input type="checkbox"/> Includes documentation of location/ provider of ancillary continuing health care (e.g., mental health or substance abuse, or other continuing specialty services) <input type="checkbox"/> Includes need for and/ or provider of case management services. <input type="checkbox"/> No , chart does not contain evidence that standard was met.	<input type="checkbox"/> Yes , chart contains evidence that standard was met. ▶ Check areas contained In the central problem list : <input type="checkbox"/> Includes history and activity of mental health and substance abuse disorders <input type="checkbox"/> Includes documentation of location/ provider of ancillary continuing health care (e.g., mental health or substance abuse, or other continuing specialty services) <input type="checkbox"/> Includes need for and/ or provider of case management services. <input type="checkbox"/> No , chart does not contain evidence that standard was met.	<input type="checkbox"/> Yes , chart contains evidence that standard was met. ▶ Check areas contained In the central problem list : <input type="checkbox"/> Includes history and activity of mental health and substance abuse disorders <input type="checkbox"/> Includes documentation of location/ provider of ancillary continuing health care (e.g., mental health or substance abuse, or other continuing specialty services) <input type="checkbox"/> Includes need for and/ or provider of case management services. <input type="checkbox"/> No , chart does not contain evidence that standard was met.

4.3 Physical assessment		
Visit period 1 January 1 - April 30, 2001.	Visit period 2 May 1 - August 31, 2001	Visit period 3 September 1 - December 31, 2001
<input type="checkbox"/> Yes , chart contains evidence that standard was met. ▶ Check areas documented In physical assessment : <input type="checkbox"/> Current and previous medications <input type="checkbox"/> Review of systems (ROS) <input type="checkbox"/> Vital signs <input type="checkbox"/> Weight <input type="checkbox"/> Height <input type="checkbox"/> Nutritional status <input type="checkbox"/> No , chart does not contain evidence that standard was met.	<input type="checkbox"/> Yes , chart contains evidence that standard was met. ▶ Check areas documented In physical assessment : <input type="checkbox"/> Current and previous medications <input type="checkbox"/> Review of systems (ROS) <input type="checkbox"/> Vital signs <input type="checkbox"/> Weight <input type="checkbox"/> Height <input type="checkbox"/> Nutritional status <input type="checkbox"/> No , chart does not contain evidence that standard was met.	<input type="checkbox"/> Yes , chart contains evidence that standard was met. ▶ Check areas documented In physical assessment : <input type="checkbox"/> Current and previous medications <input type="checkbox"/> Review of systems (ROS) <input type="checkbox"/> Vital signs <input type="checkbox"/> Weight <input type="checkbox"/> Height <input type="checkbox"/> Nutritional status <input type="checkbox"/> No , chart does not contain evidence that standard was met.

4.4 Laboratory data		
Visit period 1 January 1 - April 30, 2001.	Visit period 2 May 1 - August 31, 2001	Visit period 3 September 1 - December 31, 2001
<input type="checkbox"/> Yes , chart contains evidence that standard was met. ▶ Check laboratory data documented from this visit: <input type="checkbox"/> CBC <input type="checkbox"/> Chemistry panel <input type="checkbox"/> LFTs <input type="checkbox"/> VDRL or RPR <input type="checkbox"/> CD4 ▶ Result: _____ cells/uL <input type="checkbox"/> Drawn, but results not documented in chart <input type="checkbox"/> Viral Load ▶ Result: _____ <input type="checkbox"/> Drawn, but results not documented in chart <input type="checkbox"/> No , chart does not contain evidence that standard was met.	<input type="checkbox"/> Yes , chart contains evidence that standard was met. ▶ Check laboratory data documented from this visit: <input type="checkbox"/> CBC <input type="checkbox"/> Chemistry panel <input type="checkbox"/> LFTs <input type="checkbox"/> VDRL or RPR <input type="checkbox"/> CD4 ▶ Result: _____ cells/uL <input type="checkbox"/> Drawn, but results not documented in chart <input type="checkbox"/> Viral Load ▶ Result: _____ <input type="checkbox"/> Drawn, but results not documented in chart <input type="checkbox"/> No , chart does not contain evidence that standard was met.	<input type="checkbox"/> Yes , chart contains evidence that standard was met. ▶ Check laboratory data documented from this visit: <input type="checkbox"/> CBC <input type="checkbox"/> Chemistry panel <input type="checkbox"/> LFTs <input type="checkbox"/> VDRL or RPR <input type="checkbox"/> CD4 ▶ Result: _____ cells/uL <input type="checkbox"/> Drawn, but results not documented in chart <input type="checkbox"/> Viral Load ▶ Result: _____ <input type="checkbox"/> Drawn, but results not documented in chart <input type="checkbox"/> No , chart does not contain evidence that standard was met.

4.5 Highly Active Antiretroviral treatment (HAART)

DHHS Guidelines for initiation of antiretroviral therapy (7/ 01):

Clinical	CD4	VL	HAART
Symptomatic; AIDS	Any value	Any value	Yes
Asymptomatic AIDS	Any value	Any value	Yes
Asymptomatic	200-350	Any value	Offer
Asymptomatic	>350	>30K bDNA >55K RT-PCR	Offer/monitor

Visit period 1: January 1 - April 30, 2001.	Visit period 2: May 1 - August 31, 2001	Visit period 3: September 1 - December 31, 2001
<p>At this visit (If multiple visits during this period, then record data from the last visit):</p> <p><input type="checkbox"/> Previous treatment regimen continued</p> <p>▶ Does chart contain documentation of assessment and reinforcement with treatment plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> HAART not indicated; continue monitoring</p> <p><input type="checkbox"/> HAART indicated, patient offered treatment, but patient declined; continue monitoring</p> <p><input type="checkbox"/> HAART indicated and initiated</p> <p>▶ Does chart contain documentation of follow-up monitoring visits?</p> <p> @ 4 weeks from treatment initiation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p> @ 8 weeks from treatment initiation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Previous HAART treatment regimen switched</p> <p>▶ Reason for change documented:</p> <p> <input type="checkbox"/> Reason for change not documented</p> <p> <input type="checkbox"/> Drug failure; suboptimal virologic response</p> <p> <input type="checkbox"/> Toxicity</p> <p> <input type="checkbox"/> Patient request</p> <p> <input type="checkbox"/> Other/specify:</p> <p>▶ Does chart contain documentation of follow-up monitoring visits?</p> <p> @ 4 weeks from treatment change <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p> @ 8 weeks from treatment change <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>▶ Was genotyping/ phenotyping conducted prior to treatment change? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>At this visit (If multiple visits during this period, then record data from the last visit):</p> <p><input type="checkbox"/> Previous treatment regimen continued</p> <p>▶ Does chart contain documentation of assessment and reinforcement with treatment plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> HAART not indicated; continue monitoring</p> <p><input type="checkbox"/> HAART indicated, patient offered treatment, but patient declined; continue monitoring</p> <p><input type="checkbox"/> HAART indicated and initiated</p> <p>▶ Does chart contain documentation of follow-up monitoring visits?</p> <p> @ 4 weeks from treatment initiation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p> @ 8 weeks from treatment initiation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Previous HAART treatment regimen switched</p> <p>▶ Reason for change documented:</p> <p> <input type="checkbox"/> Reason for change not documented</p> <p> <input type="checkbox"/> Drug failure; suboptimal virologic response</p> <p> <input type="checkbox"/> Toxicity</p> <p> <input type="checkbox"/> Patient request</p> <p> <input type="checkbox"/> Other/specify:</p> <p>▶ Does chart contain documentation of follow-up monitoring visits?</p> <p> @ 4 weeks from treatment change <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p> @ 8 weeks from treatment change <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>▶ Was genotyping/ phenotyping conducted prior to treatment change? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>At this visit (If multiple visits during this period, then record data from the last visit):</p> <p><input type="checkbox"/> Previous treatment regimen continued</p> <p>▶ Does chart contain documentation of assessment and reinforcement with treatment plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> HAART not indicated; continue monitoring</p> <p><input type="checkbox"/> HAART indicated, patient offered treatment, but patient declined; continue monitoring</p> <p><input type="checkbox"/> HAART indicated and initiated</p> <p>▶ Does chart contain documentation of follow-up monitoring visits?</p> <p> @ 4 weeks from treatment initiation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p> @ 8 weeks from treatment initiation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Previous HAART treatment regimen switched</p> <p>▶ Reason for change documented:</p> <p> <input type="checkbox"/> Reason for change not documented</p> <p> <input type="checkbox"/> Drug failure; suboptimal virologic response</p> <p> <input type="checkbox"/> Toxicity</p> <p> <input type="checkbox"/> Patient request</p> <p> <input type="checkbox"/> Other/specify:</p> <p>▶ Does chart contain documentation of follow-up monitoring visits?</p> <p> @ 4 weeks from treatment change <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p> @ 8 weeks from treatment change <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>▶ Was genotyping/ phenotyping conducted prior to treatment change? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

4.6

Primary Preventive Therapy
2001 USPHS/IDSA Guidelines for the Prevention of Opportunistic Infection In Persons Infected with Human Immunodeficiency Virus

a-Pneumocystis carinii pneumonia (PCP)
Indication: CD4 <200/ uL or history of oropharyngeal candidiasis
Preferred tx: 1 DS TMP-SMX q d

b-Toxoplasmic Encephalitis
Indication: Toxoplasma-seropositive patients with CD4 <100/ uL
Preferred tx: 1 DS TMP-SMX q d

c-Macobacterium avium Complex (MAC)
Indication: CD4 <50/ uL
Preferred tx: Clarithromycin 500 mg bid or azithromycin 1200 mg P) weekly

d-Cytomeglovirus Disease (CMV)
Indication: CMV seropostive and CD4 <50/ uL
Preferred tx: Valganciclovir 900 mg PO bid x 21 days, then 900/ mg qd [and regular fundusoscopic examinations]

Visit period 1 January 1 - April 30, 2001.	Visit period 2 May 1 - August 31, 2001	Visit period 3 September 1 - December 31, 2001
<p>a-Pneumocystis carinii pneumonia (PCP)</p> <p><input type="checkbox"/> Preventive therapy not clinically indicated at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, patient started on treatment at this visit</p> <p><input type="checkbox"/> Patient maintained on treatment</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient declines treatment at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient's chart does not contain documentation on treatment</p> <p>b-Toxoplasmic Encephalitis</p> <p><input type="checkbox"/> Preventive therapy not clinically indicated at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, patient started on treatment at this visit</p> <p><input type="checkbox"/> Patient maintained on treatment</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient declines treatment at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient's chart does not contain documentation on treatment</p>	<p>a-Pneumocystis carinii pneumonia (PCP)</p> <p><input type="checkbox"/> Preventive therapy not clinically indicated at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, patient started on treatment at this visit</p> <p><input type="checkbox"/> Patient maintained on treatment</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient declines treatment at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient's chart does not contain documentation on treatment</p> <p>b-Toxoplasmic Encephalitis</p> <p><input type="checkbox"/> Preventive therapy not clinically indicated at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, patient started on treatment at this visit</p> <p><input type="checkbox"/> Patient maintained on treatment</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient declines treatment at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient's chart does not contain documentation on treatment</p>	<p>a-Pneumocystis carinii pneumonia (PCP)</p> <p><input type="checkbox"/> Preventive therapy not clinically indicated at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, patient started on treatment at this visit</p> <p><input type="checkbox"/> Patient maintained on treatment</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient declines treatment at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient's chart does not contain documentation on treatment</p> <p>b-Toxoplasmic Encephalitis</p> <p><input type="checkbox"/> Preventive therapy not clinically indicated at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, patient started on treatment at this visit</p> <p><input type="checkbox"/> Patient maintained on treatment</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient declines treatment at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient's chart does not contain documentation on treatment</p>

<p>c-Macobacterium avium Complex (MAC)</p> <p><input type="checkbox"/> Preventive therapy not clinically indicated at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, patient started on treatment at this visit</p> <p><input type="checkbox"/> Patient maintained on treatment</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient declines treatment at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient's chart does not contain documentation on treatment</p> <p>d-Cytomeglovirus Disease (CMV)</p> <p><input type="checkbox"/> Preventive therapy not clinically indicated at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, patient started on treatment at this visit</p> <p><input type="checkbox"/> Patient maintained on treatment</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient declines treatment at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient's chart does not contain documentation on treatment</p>	<p>c-Macobacterium avium Complex (MAC)</p> <p><input type="checkbox"/> Preventive therapy not clinically indicated at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, patient started on treatment at this visit</p> <p><input type="checkbox"/> Patient maintained on treatment</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient declines treatment at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient's chart does not contain documentation on treatment</p> <p>d-Cytomeglovirus Disease (CMV)</p> <p><input type="checkbox"/> Preventive therapy not clinically indicated at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, patient started on treatment at this visit</p> <p><input type="checkbox"/> Patient maintained on treatment</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient declines treatment at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient's chart does not contain documentation on treatment</p>	<p>c-Macobacterium avium Complex (MAC)</p> <p><input type="checkbox"/> Preventive therapy not clinically indicated at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, patient started on treatment at this visit</p> <p><input type="checkbox"/> Patient maintained on treatment</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient declines treatment at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient's chart does not contain documentation on treatment</p> <p>d-Cytomeglovirus Disease (CMV)</p> <p><input type="checkbox"/> Preventive therapy not clinically indicated at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, patient started on treatment at this visit</p> <p><input type="checkbox"/> Patient maintained on treatment</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient declines treatment at this visit</p> <p><input type="checkbox"/> Preventive therapy clinically indicated, but patient's chart does not contain documentation on treatment</p>
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4.7 Pain Assessment/ Management: Chart contains documentation of assessment of patient's level of pain.

Visit period 1 January 1 - April 30, 2001.	Visit period 2 May 1 - August 31, 2001	Visit period 3 September 1 - December 31, 2001
<p><input type="checkbox"/> Yes, chart contains evidence that standard was met.</p> <p> ▶ <input type="checkbox"/> Patient assessment indicates that patient is experiencing a level of pain requiring treatment</p> <p><input type="checkbox"/> No, chart does not contain evidence that standard was met.</p>	<p><input type="checkbox"/> Yes, chart contains evidence that standard was met.</p> <p> ▶ <input type="checkbox"/> Patient assessment indicates that patient is experiencing a level of pain requiring treatment</p> <p><input type="checkbox"/> No, chart does not contain evidence that standard was met.</p>	<p><input type="checkbox"/> Yes, chart contains evidence that standard was met.</p> <p> ▶ <input type="checkbox"/> Patient assessment indicates that patient is experiencing a level of pain requiring treatment</p> <p><input type="checkbox"/> No, chart does not contain evidence that standard was met.</p>

4.8 Patient Education: Chart contains documentation of patient education, which may include topics discussed, methods used, patient response, others involved in education and follow-up.

Visit period 1 January 1 - April 30, 2001.	Visit period 2 May 1 - August 31, 2001	Visit period 3 September 1 - December 31, 2001
<input type="checkbox"/> Yes , chart contains evidence that standard was met. <input type="checkbox"/> No , chart does not contain evidence that standard was met.	<input type="checkbox"/> Yes , chart contains evidence that standard was met. <input type="checkbox"/> No , chart does not contain evidence that standard was met.	<input type="checkbox"/> Yes , chart contains evidence that standard was met. <input type="checkbox"/> No , chart does not contain evidence that standard was met.

4.9 Address advanced directives, including "DNR" status at an appropriate time in the course of illness

Visit period 1 January 1 - April 30, 2001.	Visit period 2 May 1 - August 31, 2001	Visit period 3 September 1 - December 31, 2001
<input type="checkbox"/> Yes , chart contains evidence that standard was met. <input type="checkbox"/> No , chart does not contain evidence that standard was met. <input type="checkbox"/> This standard not applicable to this client's situation; specify:	<input type="checkbox"/> Yes , chart contains evidence that standard was met. <input type="checkbox"/> No , chart does not contain evidence that standard was met. <input type="checkbox"/> This standard not applicable to this client's situation; specify:	<input type="checkbox"/> Yes , chart contains evidence that standard was met. <input type="checkbox"/> No , chart does not contain evidence that standard was met. <input type="checkbox"/> This standard not applicable to this client's situation; specify:

4.10 Documentation of reporting of all reportable illnesses to the local health department

Visit period 1 January 1 - April 30, 2001.	Visit period 2 May 1 - August 31, 2001	Visit period 3 September 1 - December 31, 2001
<input type="checkbox"/> Yes , chart contains evidence that standard was met. <input type="checkbox"/> No , chart does not contain evidence that standard was met. <input type="checkbox"/> This standard not applicable to this client's situation/ No new reportable illnesses diagnosed.	<input type="checkbox"/> Yes , chart contains evidence that standard was met. <input type="checkbox"/> No , chart does not contain evidence that standard was met. <input type="checkbox"/> This standard not applicable to this client's situation/ No new reportable illnesses diagnosed.	<input type="checkbox"/> Yes , chart contains evidence that standard was met. <input type="checkbox"/> No , chart does not contain evidence that standard was met. <input type="checkbox"/> This standard not applicable to this client's situation/ No new reportable illnesses diagnosed.

4.11 Pregnancy status								
Visit period 1 January 1 - April 30, 2001.	Visit period 2 May 1 - August 31, 2001	Visit period 3 September 1 - December 31, 2001						
4.11a Is client pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes ▶ If Yes , ▶ GOTO question 4.11b, below	4.11a Is client pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes ▶ If Yes , ▶ GOTO question 4.11b, below	4.11a Is client pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes ▶ If Yes , ▶ GOTO question 4.11b, below						
<div> <div>4.11b Provision of antiretroviral therapy during pregnancy</div> <table border="1"> <tbody> <tr> <td>Antepartum ZDV (Retrovir) dose:</td> <td>100 mg PO 5x daily (or ZDV 200mg po TID or ZDV 300mg po bid), begun after 14 weeks gestation to delivery</td> </tr> <tr> <td>For women on ARV therapy prior to/during pregnancy</td> <td>Consider adding or substituting ZDV if on other NRTIs. (Note do not administer ZDV and d4T (Zerit).</td> </tr> <tr> <td>If decision is to temporarily stop ARV therapy</td> <td>Then stop all drugs together and restart them together after end of 1st trimester.</td> </tr> </tbody> </table> </div> <div> <input type="checkbox"/> Yes, chart contains evidence that standard was met. <input type="checkbox"/> No, chart does not contain evidence that standard was met. ▶ Pregnancy Identified at ____ weeks gestation </div>			Antepartum ZDV (Retrovir) dose:	100 mg PO 5x daily (or ZDV 200mg po TID or ZDV 300mg po bid), begun after 14 weeks gestation to delivery	For women on ARV therapy prior to/during pregnancy	Consider adding or substituting ZDV if on other NRTIs. (Note do not administer ZDV and d4T (Zerit).	If decision is to temporarily stop ARV therapy	Then stop all drugs together and restart them together after end of 1st trimester.
Antepartum ZDV (Retrovir) dose:	100 mg PO 5x daily (or ZDV 200mg po TID or ZDV 300mg po bid), begun after 14 weeks gestation to delivery							
For women on ARV therapy prior to/during pregnancy	Consider adding or substituting ZDV if on other NRTIs. (Note do not administer ZDV and d4T (Zerit).							
If decision is to temporarily stop ARV therapy	Then stop all drugs together and restart them together after end of 1st trimester.							

Section 5. Annual clinical care

Instructions:

This section contains clinical items which are to be addressed and documented by clinicians on an annual basis. Some of these items may have been addressed during the initial/ baseline clinical assessment (Section 3, p 4), and others may have been addressed during follow-up/ monitoring appointments (Section 4, p 7) but standards compliance must **also** be documented in this section.

<p>5.1 Documentation of PPD placement</p> <p>Documentation of patient's return for PPD reading and test result</p>	<p><input type="checkbox"/> Yes, chart contains evidence that PPD skin test was placed.</p> <p> ▶ Was patient's PPD read and documented in chart?</p> <p> <input type="checkbox"/> Yes ▶ If Yes, PPD result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive (induration \geq 5mm)</p> <p> <input type="checkbox"/> No ▶ If No, does chart contain documented attempts to contact clients? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> No, chart does not contain evidence that standard was met.</p> <p><input type="checkbox"/> This standard not applicable to this client's situation; specify:</p> <p> <input type="checkbox"/> Patient has prior positive test; PPD testing not indicated</p> <p> <input type="checkbox"/> Other/ Specify:</p>										
<p>5.2 Immunization: Influenza (Seasonally provided)</p>	<p><input type="checkbox"/> Yes, chart contains evidence that standard was met.</p> <p><input type="checkbox"/> No, chart does not contain evidence that standard was met.</p> <p><input type="checkbox"/> This standard not applicable to this client's situation; specify:</p> <p> <input type="checkbox"/> Patient did not have visit during fall/ winter months when influenza Immunization Is given.</p> <p> <input type="checkbox"/> Patient offered, but declined immunization.</p>										
<p>5.3 Syphilis serology: VDRL or RPR</p>	<p><input type="checkbox"/> Yes, chart contains evidence that standard was met.</p> <p><input type="checkbox"/> No, chart does not contain evidence that standard was met.</p>										
<p>5.4 Documentation of annual PAP smear, and result with appropriate follow-up</p> <table border="1" data-bbox="226 1084 688 1479"> <thead> <tr> <th>PAP</th> <th>Management</th> </tr> </thead> <tbody> <tr> <td>Severe inflammation</td> <td>Evaluate for infection; repeat PAP, preferably within 2 –3 months</td> </tr> <tr> <td>Atypia, atypical squamous cells of undetermined significance (ASCUS)</td> <td>Follow-up PAP without colposcopy every 4-6 months x 2 years until 3 are negative; if 2nd report of ASCUS, perform colposcopy</td> </tr> <tr> <td>Low-grade squamous intraepithelial; lesion (LSIL)</td> <td>Colposcopy +/- biopsy or follow with PAP smear q 4 – 6 months with colposcopy and biopsy if repeat smears are abnormal.</td> </tr> <tr> <td>Invasive carcinoma</td> <td>Colposcopy with biopsy or conization; treat with surgery</td> </tr> </tbody> </table>	PAP	Management	Severe inflammation	Evaluate for infection; repeat PAP, preferably within 2 –3 months	Atypia, atypical squamous cells of undetermined significance (ASCUS)	Follow-up PAP without colposcopy every 4-6 months x 2 years until 3 are negative; if 2 nd report of ASCUS, perform colposcopy	Low-grade squamous intraepithelial; lesion (LSIL)	Colposcopy +/- biopsy or follow with PAP smear q 4 – 6 months with colposcopy and biopsy if repeat smears are abnormal.	Invasive carcinoma	Colposcopy with biopsy or conization; treat with surgery	<p><input type="checkbox"/> Yes, chart contains evidence that standard was met</p> <p> ▶ If result was abnormal, was follow-up documented?</p> <p> <input type="checkbox"/> Yes</p> <p> <input type="checkbox"/> No</p> <p><input type="checkbox"/> No, chart does not contain evidence that standard was met.</p> <p><input type="checkbox"/> This standard not applicable: Client Is male.</p>
PAP	Management										
Severe inflammation	Evaluate for infection; repeat PAP, preferably within 2 –3 months										
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Invasive carcinoma	Colposcopy with biopsy or conization; treat with surgery										

**BCHD Quality Improvement Project
Primary Care Medical Services
Agency Survey**

- ▶ Agency Name:
- ▶ Address:
- ▶ Person completing form:
- ▶ Telephone:
- ▶ Fax:
- ▶ e-mail:

Please check all of the services that your agency **directly provided**, on-site during calendar year 2001. **Note:** Do not limit your responses only to services funded by Ryan White Care Act.

- | | |
|------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Ambulatory Health Care | <input type="checkbox"/> Food/ Nutrition |
| <input type="checkbox"/> Mental Health Services | <input type="checkbox"/> Housing Assistance |
| <input type="checkbox"/> Outreach | <input type="checkbox"/> Legal Services |
| <input type="checkbox"/> Substance Abuse Treatment | <input type="checkbox"/> Enriched Life Skills |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Co-morbidity Services |
| <input type="checkbox"/> Buddy/ Companion | <input type="checkbox"/> Viral Load Testing |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Other/ Specify: |
| <input type="checkbox"/> Client Advocacy | |
| <input type="checkbox"/> Counseling | |
| <input type="checkbox"/> Dental Care | |
| <input type="checkbox"/> Direct Emergency Assistance | |

Please check all of the services that your agency does not directly provide on-site, but have **established referral agreements** with other agencies to provide these services to your clients during calendar year 2001. **Note:** Do not limit your responses only to services funded by Ryan White Care Act.

- | | |
|------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Ambulatory Health Care | <input type="checkbox"/> Food/ Nutrition |
| <input type="checkbox"/> Mental Health Services | <input type="checkbox"/> Housing Assistance |
| <input type="checkbox"/> Outreach | <input type="checkbox"/> Legal Services |
| <input type="checkbox"/> Substance Abuse Treatment | <input type="checkbox"/> Enriched Life Skills |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Co-morbidity Services |
| <input type="checkbox"/> Buddy/ Companion | <input type="checkbox"/> Viral Load Testing |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Other/ Specify: |
| <input type="checkbox"/> Client Advocacy | |
| <input type="checkbox"/> Counseling | |
| <input type="checkbox"/> Dental Care | |
| <input type="checkbox"/> Direct Emergency Assistance | |

Standards of Care

A. Licensing, Knowledge, Skills and Experience

1. Do all staff involved in the delivery of health care have the appropriate and current professional licensure from the state of Maryland?
☐ Yes ☐ No
2. Is professional supervision and/ or consultation of clinical staff provided by practitioners who have extensive HIV expertise and active HIV practices themselves?

☐ Yes ☐ No
3. Do clinical staff who provide direct HIV clinic services have an active practice of greater than twenty HIV-infected patients?

☐ Yes ☐ No

▶ If No, specify the number of HIV-infected patients receiving primary care at the agency during CY2001.
4. Are medical practitioners encouraged to develop the expertise needed to provide the specialized care that HIV-infected patients need?

☐ Yes ☐ No

▶ If Yes, describe how this is achieved?
5. Do clinical staff have a minimum of 20 CME hours per year in HIV/ AIDS-specialty course work?

☐ Yes ☐ No

B. Patient Rights and Confidentiality

6. Does the agency have written policies and procedures that assure patient confidentiality with regard to transmission, maintenance and security of medical information?

☐ Yes ☐ No

7. Does the agency have written policies and procedures regarding:

- | | | |
|------------------------------|-----------------------------|---------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Patient grievance |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Confidentiality |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eligibility for service |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Patient rights and provider expectations of patients and termination of care by either the patient or the provider. |

C. Access, Care and Provider Continuity

8. What are your routine operating hours? (Both weekday and weekend)

9. Does the agency have a procedure in place for 24-hour call coverage?

- ☐ Yes ☐ No

▶ If **No**, describe what patients are instructed to do to receive care during non-business hours.

10. Does the agency have mechanisms in place for urgent care evaluation and/ or triage?

- ☐ Yes ☐ No

▶ If Yes, describe these mechanisms.

11. Does the agency have mechanisms in place for referral to inpatient care and return to ambulatory care?

- ☐ Yes ☐ No

12. Does the agency's no show rate for ambulatory care exceed 50%?

☐ Yes ☐ No ☐ Agency's no show rate is not calculated

► If Yes, what procedures have you implemented to attempt to reduce the rate of no-shows? (Check all that apply.)

- ☐ Pre-appointment phone call
- ☐ Post-appointment phone call
- ☐ Pre-appointment letter
- ☐ Post-appointment letter
- ☐ Home visit
- ☐ Contact client's case manager
- ☐ Changed hours at agency
- ☐ Changed location of services
- ☐ Provide/ coordinate transportation to agency
- ☐ Provide child care
- ☐ Added PWAs to staff
- ☐ Other/ specify:

13. Check the services which are provided: 1) directly by your agency, 2) arranged by referral, 3) are not available. (Check only one in each row.)

Subspecialty/ Service	Directly	By referral	Not available
a. Gastroenterology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Neurology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Psychiatry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Ophthalmology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Dermatology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Obstetrics & Gynecology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Endocrinology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Cardiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Oncology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Dentistry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Palliative Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Social work and case management services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Nutritional counseling from a Registered Dietician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Substance abuse treatment services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Question 13, continued next page

Question 13, continued

Subspecialty/ Service	Directly	By referral	Not available
p. ART counseling/ therapy for pregnant women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Information with inherited coagulopathies and referral to the local federally funded hemophilia treatment center	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Social work and case management services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Access to clinical investigations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. Complementary therapies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u. Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. Massage Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w. Education of the patient/ family/ significant other and/ or caregiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Are there procedures in place to assure continuity with referring providers?

☐ Yes ☐ No

15. Does the agency have an on-going quality improvement/ quality assurance program that identifies areas for improvement and subsequent actions taken?

☐ Yes ☐ No